Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month Day **Physician** Stanley June 19 1999 6:30 AM Bohn /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Manor Care Bethesda Montgomery Bethesda 8. Date of Birth (Month, Dey, Year) June 24, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthpiace (State or Foreign Country) 7. Age (In yrs. last birthdey) 1⊠M 2□ F Months Deys Hours Min. 579-07-4839 89 Yrs 1909 Washington, D.C. Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Montgomery Bethesda 10f, Zip Code 10g. Citizen of What Country? 10e. Street end Number 20817 6530 Democracy Blvd. United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 ☐ Yes 2 📉 No If Yes, Give Yeer or Dates: 1 Never Married 2 ☐ Married Specify: White 1 Yes 2 No Specify: à 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Salesman Vacuum 10 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Charles Sylvester Bohn Marguerite Heron 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marguerite F. Caruso/Sister 13002 Atlantic Ave., Rockville, Maryland 20851 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) June 24, 1999 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Buriai 2 □ Cremetion 3 □ Removal from Stete Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 22. Neme and Address of Facility 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M00198 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 0 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Sepsis Few Weeks Due to (or es e consequence of): Examine Osteomyelosis Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Funeral

Director

rithan "natural", or items 23a or 28a-f ahow the Medical Exemples must be notified at

permit. Pegas 1 and 2 should be filed within 72 hours after death v. Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a eny Injury or other traumatic event, the Medical Examples mustle.

Baltimore, Maryland 21215-0020

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attending physicien and for use as the burial-transit the signed by t should I has this certificate Hospital or Attanding Physician:
24 hours after deeth.
 Funeral Director: After this certifica director, funeral

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filled in by

completely

To the Vithin 2

edical

The lew requires that the death certificate be executed

Box 68760.

Records,

Division of Vital

Be Certification: To

25. Was cese referred to medical exeminer? 1 Yes 2 No 27. Menner of Deeth 5 Pending investigation 1 X Natural 2 Accident 6 Could not be determined

Hospital: 28a. Date of Injury (Month, Dey Year)

1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

11119 Rockville Pike

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one)

281. Location (Street and Number or Rurel Route Number, City or Town, Stete)

28d. Describe how Injury occurred

29a. Certifier (Check only one) 29b. Signeture end title of certifier

3 Suicide

4 Homicide

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Dey, Year)

401, Rockville, Maryland 20852

20

D42518

June 21, 1999

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

Gul Chablani, M.D. 31. Date filed (Month, Dey, Yeer)

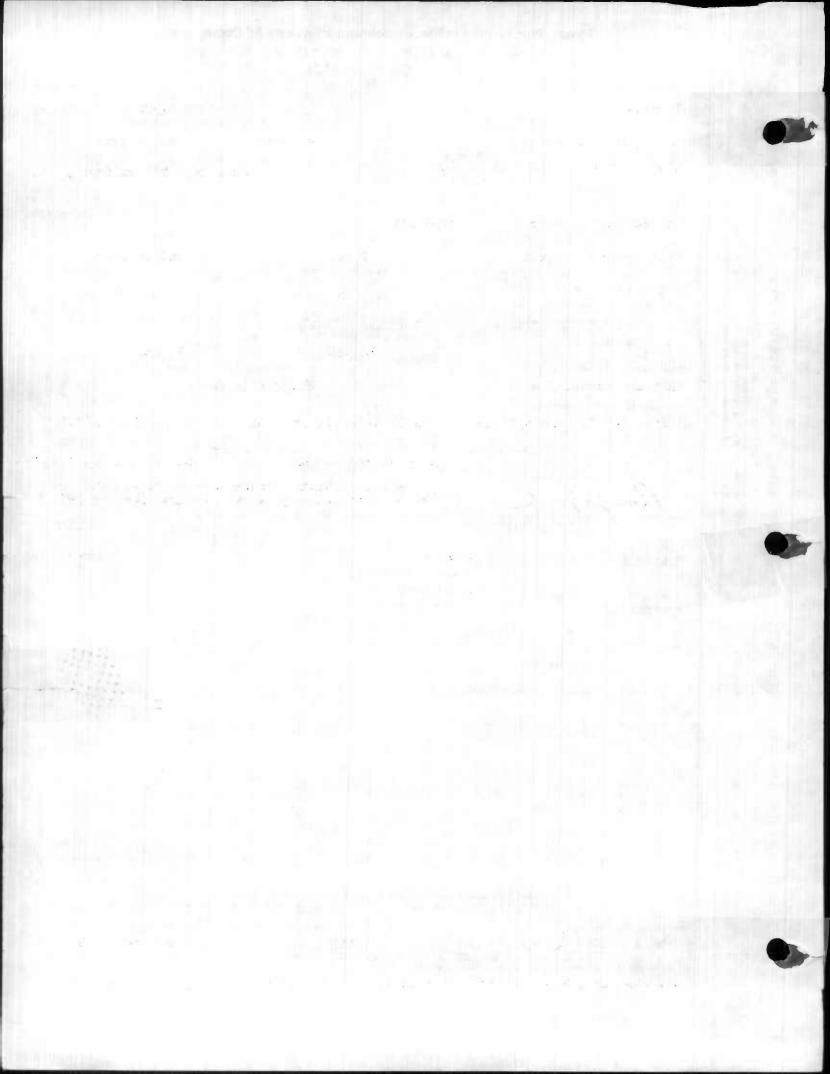
JUN 2 3 1999

32. Registrer's Signature

Sporker

State Registrar

DHMH 16 Rev 6/95



				il ylalla / I	Certificate		id Mentar i	Reg. No.	9 21502	
Physic	ian	Decedent's Name (First, Middle, Last,					2. Date of D Month	eath Day	3. Time of Death	1
/Medi	cai	Jessie Shearer Bor					June 2		5:07PM	
Exami	ner	4a. Facility Name (If not institution, give					, or Location of Dea			
		Manor Care-Potomac 5. Social Security Number 6. Security Number		(In yrs. last bii	thday) If Under 1 Yo	Potomac ear If Under 24			gomery	
Funeral Director		579-56-2872	M 202 F	96	Yrs. Months Da			Dav. Year)	9. Birthplace (State or Forei Country) Scotland	ign
pus *		Usual Residence of Dacedent 10a. State 10b, County		10c. City, Tow	n or Location				404 114- 01-11-1	** -
laryla sho	5	Maryland Montgomer	v	Rockvi					10d. Inside City Limi 1 ☐ Yes 2 ☑ N	
28a-	Director	10e. Street and Number			10f. Zip Coo	lo.		40- 00		
death with the Maryland ms 23a or 28a-f show			4204					10g. Citizen of		
Jeath F 2	Funeral	10201 Grosvenor P1	12. Was Decedent E	ver in U.S.	208.		? (Specify Yes or N	United	States ce - American Indian,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at anote.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	111.0	13. Was Decedent If Yes, specify (Puerto Ricen, etc.)	Bia Specif	ck, White, etc.	
2 hou		15. Decedent's Edu		16a	Dacedant's Usual Oc	cunation		16b Kind of 8	usiness/industry	_
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Ment Ment rked rtic e	To	James Shearer				Marga	ret Casse	11s		
and and is me		19a. Informant's Name/Ralationship (Ty)	pe, Print)	196	. Mailing Address (Str	eet and Number o	or Rural Route Num	ber, City or Town,	State, Zip Code)	
and ealth m 27		Leo A. Borah, Jr.	/Step-son				ce,#204,		e, MD 20852	
f of H		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R	emoval from State	cemete	f Disposition (Name or ry, crematory or other	place) Tune	23, 1999		City or Town, State	
tant:		4 ☐ Donation 5 ☐ Other (Specify)	. ^	Montg	omery Crem	atorium,	inc.		la, Maryland	
Depar Impor any In		21. Signature of Funeral Service License	201						y Funeral Home	
00560		MAY	Ilun MO	0689	Bethesda. Bet	chesda, N	nase, Inc Maryland	20814-35	isconsin Aven	ue
Physician		23a art 1 Enter the diabase, or compli- noch or hear name. List only on	cations that coused to e cause on each line	the death.	t enter the mode of	dying, such as cei	rdiac or respiratory	arrest,	Approximate Interval Between Onset and Death	
/Medicai Examiner		Immediate Cause (Final disease or condition resulting in death)	Dehydra	tion					days	
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ifficate be executed g physician and as the buriel-transit	edicai	Cause (Disaase or Injury that initiated events							İ	
E 00 66		resulting In death) Last	Di	ue to (or as a c	consequence of):					
	2	d	•							
iras that tha death cer signed by the attendin d be detached for use	Physician/M	Part II. Other significant conditions con	tributing to death but	not resultino in	the underlying cause	oiven In Part I	23b. Dic	I tobacco use co	ntribute to the cause of deat	h?
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gned be de	by	Peripheral Vascul	ar Diseas	е						
been shoul	Completed	Hypertension					24a. Wa	s an autopsy iormed?	24b. Were autopsy findings available prior to completion of ceuse of death?	3
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certifi	Be C	25. Was casa referred to medicel examiner?	ospital:			Other	Daath (Check only			
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tending leath. tor: After the fune	Certification:	1 ⊠ Natural 5 ☐ Panding 2 ☐ Accident investigation 3 ☐ Sulcide 6 ☐ Could not be	(Month, Day	Year) II	njury M	njury at Vork? Yes 2 No				
s after or At s after or bi Direct ed in by	Certif	4 Homicida datermined	28e. Place of Injury building, etc.	y - At homa, fa (Spacify)	rm, street, factory, offi	C 0	28f. Location City or To	(Street and Numb own, State)	er or Rural Routa Number,	
To the Rospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifiar (Check only one) 1 ☑ Certifying Physic 2 ☐ Medical Examin	clan: To the best of a er: On the basis of a and manner state	xamination and	, death occurred at the d/or investigation, in m	time, date and pi y opinion, daath o	lace, and due to the occurred at the time	cause(s) and ma , date and place,	annar as stated. and dua to the ceuse(s)	
To the within 2 Comple		29b. Signature and title of certifier	1/2	oly		38781			d (Month, Day, Year) 2, 1999	
	İ	30. Name and address of person who cor	npleted ceusa of daa	ath (Item 30a) (Type, Print)					_
		Michael J. Grady,	/			Avenue	, N.W., W	ashingto	n, DC 20016	
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar							-

Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

JUN 2 5 1999



B. Sparks

Meder of Graly

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Tyrone Bratton 1330 4b. City, Town, or Location of Death 21 1999 /Medical 4a Facility Neme (Il not institution, give street and number) 4c. County of Death Examiner Silver Spring Fox Chase Rehabilitation and Nursing Center Montgomery If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplaca (State or Foreign Country)
Aug. 13, 1955 Washington, DC 6. Sex 12 M 2 ☐ F 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Montha Days Hours 43 Yrs. 578-72-0277 Director Usual Residence of Decedent the Manfand 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show Exeminer must be notified at 1 ☐ Yes 2√ No Directo Maryland | Prince George's Oxon Hill 10e. Street and Number 10f. Zio Code 10c. Citizen of What Country? 726 Neptune Avenue 20745 United States Funeral 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Wea Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus Bleck, White, etc. 72 hours after 1 Never Married 2 N Merried 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0020 'natural', or 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Hygiene. other then "naturn ent, the Medical I Completed 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nah any injury or other traumatic event, the Medica 2008. (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) 12 Truck Driver 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Robert Bratton Dauphine Sadler Bratton 0 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 903 Marcy Avenue, #104, Oxon Hill, Maryland 20745 Renee Bratton (wife) 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stafe 6-22-99 Beltsville, Maryland Chesapeake Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Facility
Rapp Funeral Services, P.A.)elm 933 Gist Avenue, Silver Spring, Maryland 20910 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Carcinoma Examiner Due to (or ea a consequence of): Examiner attending physician and I for use as the buriel-transit The law requires that the deeth certificate be executed Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760. Physician/Medical Due to (or es e consequence of) P.O. 1 signed by the sid be detached Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Intra Venus abuse Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s 1 Yes 2 NO 1 ☐ Yes 2 No certificate of Vital at or Attending Physicien: The after death.

i Director: After this certificated in by the funeral director, participates and the funeral director, participates and the funeral director, participates and partic 8 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yea 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. fnjury at Work? 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, atreet, fectory, office building, etc. (Specify) 4 Homicide etaly filed in t 24 hours US Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the if un completely t 29b. Signature and title of certifier 29c. License number 29d. Dafe signed (Month, Day, Year) Physician) 2 June 22, Doo 52255 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) M. Ejaz, M.D. 8609 2nd Ave #404B

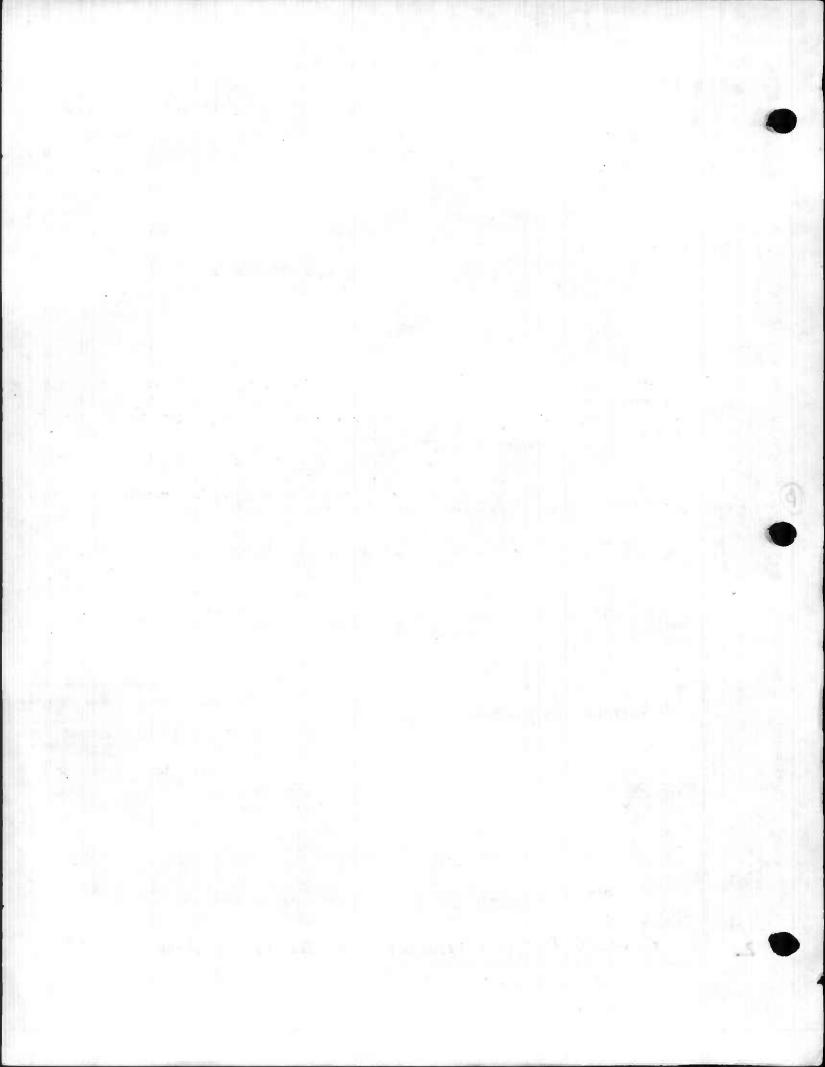
31. Date filed (Month, Day, Year)

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32. Registrar's Signeture

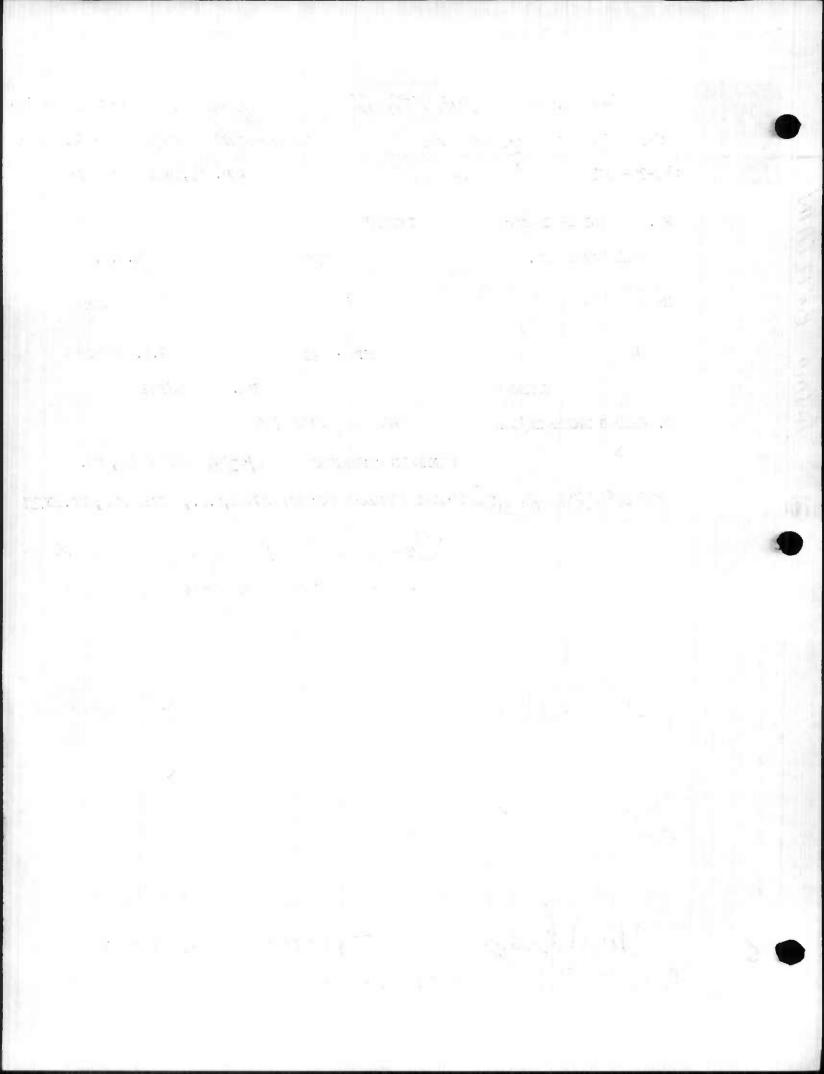
4. Silver String, MD 20910 State Registrar

DHMH 16 Rev 6/95

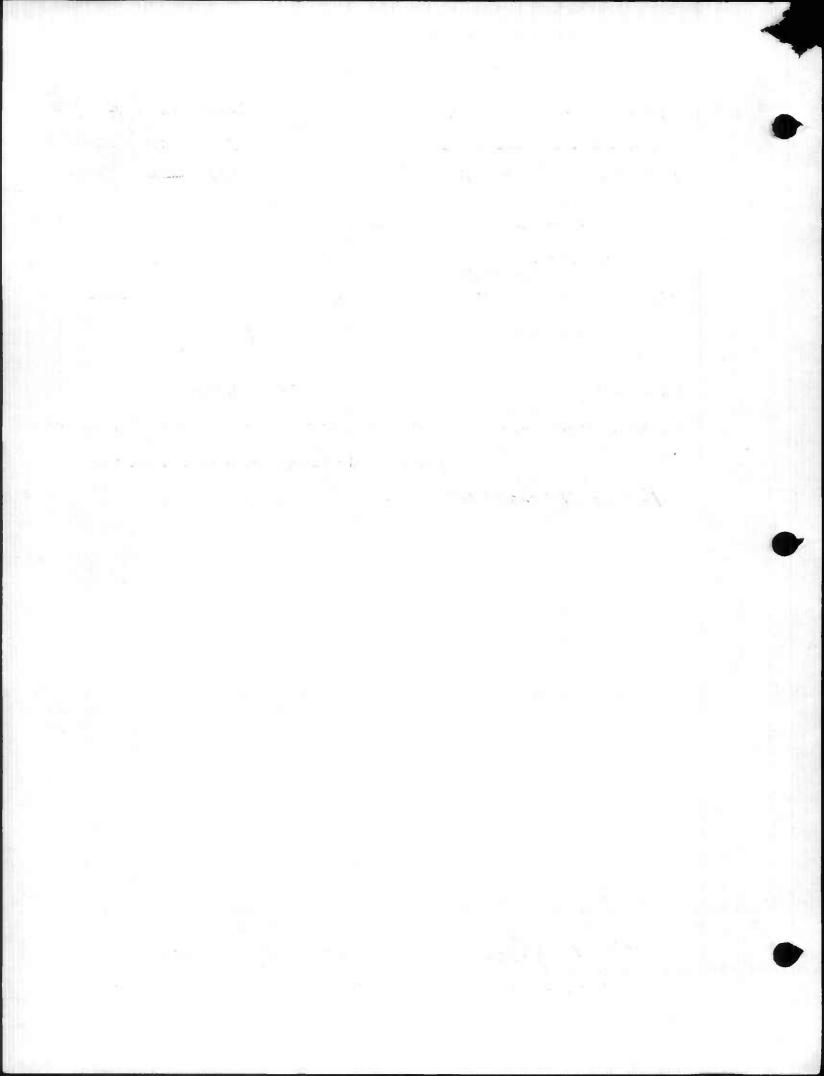


			State of Ma		Department of Certificate of	Health and Mental H	ygiene 99 21504
	Physic /Medi			BRIT	TAIN	2. Date of I	Deeth Day 1999 3. Time of Death 2 20 1999 5:12 Am
	Exami Funeral Director		5. Social Security Number 6. Sex 7. Age 1 M 20 F	7 TAL (In yrs. last birth	hdey) If Under 1 Yee Months Days	4b. City, Town, or Leation of De LAND HITM If Under 24 Hrs. B. Date of It (Month), AUG.	4c. County of Deeth PRINCE GEORGES Birth Dey, Year) 9. Birthplace (State or Foreign Country) 25,1920 GEORGIA
1 BRITTAIN	nin 72 hours efter death with the Maryland n "natural", or freme 23a or 28s-1 show	Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD. PRINCE GEORGES 10e. Street end Number 6411 NAVAL AVE. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) L 10b. County 12 Wes Decedent Armed Forces? 1 Yes 2 When Yeer or Dates: 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5-1)	10c. City, Town	I.ANHAM 10f. Zip Code 13. Was Decedent of If Yes, specify Cui 1 Yes 2 No Decedent's Usual Occu (Give kind of work done life. DO NOT use retire)	D706 Hispanic Origin? (Specify Yes or I ban, Mexican, Puerto Rican, etc.) Specify: Upation a during most of working	10d. fnside City Limits 1 ☑ Yes 2 □ No 10g. Citizen of Whet Country? U.S.A. No- 14. Rece - American Indian, Black, White, etc. Specify: WHITE 16b. Kind of Business/Industry
Thelma	as 1 and 2 should be of Heeith and Mental item 27 is marked or other traumatic eve	To Be Co	17. Fether's Name (First, Middle, Last) UNKNOWN 19a. Informant's Name/Relationship (Type, Print) T. VICTOR BRITTAIN/SON 20a. Method of Disposition 1	20b. Place of cemetery	Mailing Address (Street SAME AS Disposition (Name of y, cremetory or other pli	18. Mother's Name (First, Middle UNK. It end Number or Rural Route Num ITEM #10 Date	SMTTH Ther, City or Town, Stete, Zip Code) 20c. Location - City or Town, State
68760.	Physician Physician and Physician Physician Physician Physician and Phys	VMedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	MOOO91 the death. Do note. Due to (or as a co	on enter the mode of dy onsequence of): onsequence of):	TUNERAL HOMES.P.	A., RIVERDALE, MD. 20737 Approximate interval Between Onset and Death M. A.L. Ym.
Bl Records, P.O. Box	aw requires that the de is been signed by the a 2 should be deteched	Completed by Physician/Me	Part II. Other significent conditions contributing to death but for the conditions contributing to death but for the conditions contributing to death but for the conditions are significant to the conditions are		the underlying cause g	24e. W. pe	d tobacco use contribute to the cause of death? Yas 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of death? Yes 2 No 1 Yes 2 No
Division of Vital Records.	To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funeral Director: Affer this certificate he completely filled in by the funeral director, page	edical Certification: To Be	29a. Certifier (Check only one) 15 Cartifying Phyaician: To the best of 2 Madical Examiler: On the basis of and menner stat	y Year) 28b. Ti fn iry - At home, fan . (Specify) f my knowledge, examination and	ime of Jury M 1 [28c. Injury M 1 [28c. I	ury et ohk? 28d. Describ ohk? 28d. Describ ohk? 28f. Location City or 7	e how Injury occurred (Street end Number or Rurel Route Number, Fown, Stete)
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DHMH 16 Rev 6/95

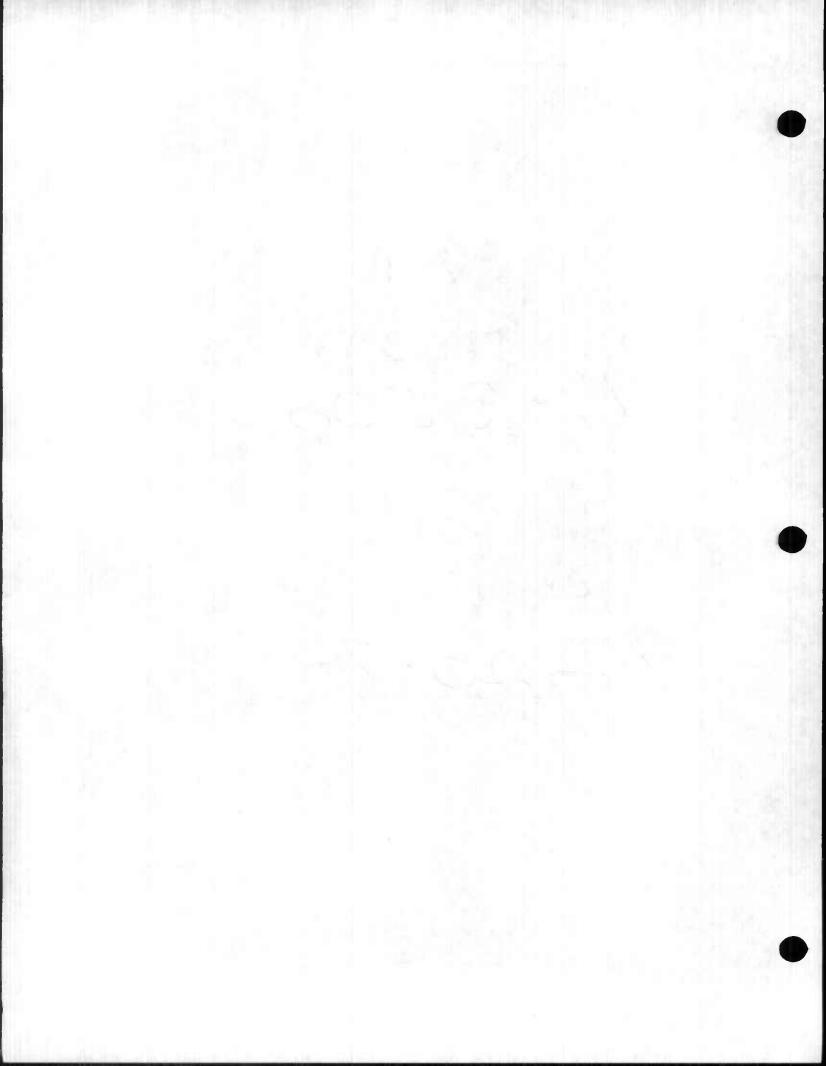


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	Examir		4a. Fecility Nema (If not institution, giva	street and numbe)			4b. City, Tov	wn, or Lo	cation of Death	1		
			Livingston Health	Care Ce	nter			Ft. W	ashi	ngton	Princ	e Geo	orges
	Funeral		5. Social Security Number 6. Sec	7. A	ge (In yrs.	last birthday)	If Undar 1 Yaar Months Deys		24 Hrs. Min.	8. Data of Birt	1893	9. Birthp	laca (State or Foreign try)
	Director		578-22-4947 ^{1L}] M 2[₹X	106	Yrs.	WOTHIS Days	Hours	IVIII.	June 5	,1883	Va	1 <i>(1))</i>
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	ser do	nue		12. Was Deceden Armed Forces 1 ☐ Yes ŽŽ	t Ever in U, ?	S. 13. V	Vas Decedent of I Yas, specify Cub	Hispanic Orig an, Mexican	gin? (Spe , Puerto l	cify Yas or No- Rican, etc.)		e - Americ ck, White,	
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an		o Be	Monroe Bumbray							edgeman			
Maryland 21215-0020	d 2 should be h and Mental 7 is marked of traumatic ev	으	19e. Informent's Name/Relationship (Ty)	pe. Print)		19b. Meilin	g Address (Street					State Zin	Code)
	100		Charles W. Brown,										id. 20744
6	Han Han offher		20e. Method of Disposition	мернем	20b. P	ece of Dispos	sition (Neme of		DITV	Data	20c. Location -		
9	Pages nert of int: If its iry or o		1X Burial 2 ☐ Cremetion 3 ☐ R 4 ☐ Donetlon 5 ☐ Other (Specify)	emovel from Stete	9		netory or other pla			/21/00			
Baltimore,	E 48 44	1	21. Signature of Funeral Service License	10 4	ne		elight C			/21/99	cattett	, va.	
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_	-	Н	23e. Pert1. Enter the disease, or compli	notions that cause	d the death							d.Mar	assas, Va.
100	Obvolelen		shock, or heart feilure. List only or	e ceusa on aach	lina.	. Do not and	or the mode of dyr	ilg, sucil es t	COTOIOC O	r respiretory er	1001,		Approximete Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final	0	_		,						
н	Examiner		disaesa or condition rasulting in death)	Reva	121	uso tt	101 mey						dylais
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	ate be executed whysician and the burial-transit	Examine	Secure tieths that conditions),	Due to /or	es a conseq	uonon off:					1	
ó	exec an an rial-tr	Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		200 10 (01	ee a conseq	odiloo oij.					!	
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dicai	that mitteled evants		Dua to (or	es e consequ	uance of):						
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Box	eath certific attending p	Physician/Me	d	l								1	
	the att	sici	Part II. Other eignificant conditions con	tributing to death	but not resu	iting in the ur	derlying cause gi	ven in Pert I.		23b. Dld t	obacco uee co	ntribute to	the cause of death?
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<u> </u>	age age	Completed								1 U Y	es 2 No	10	Yes 2 No
Vital	certifica rector, p	Be	25. Wes casa refarred to medical exeminer?			_		26. Place	of Deeth	(Check only o	ne)		
of <	5 00	To	1 Yas 2 No	lospitel:	ient 2	ER/Outpatien	t 3□ DOA Oti	har: 40 Nu	rsing Hor	na 5□Rasid	ence 6 Oth	er (Specify	<i>'</i>)
			27. Manner of Death 1 ☑ Netural 5 ☐ Pending	28a. Date of Inj	ury av Year)	28b. Time of Injury	28c. Inju Wo	ry et rk?	2	28d. Dascribe h	ow injury occur	red	
0	Attending ir death. ector: After by the fune	atic	2 Accident Investigation					Yas 2□N	No				
Division	f or Attend efter death Director: /	Certification:	3 Suicide 6 Could not be determined	28e. Plece of Ir building, e	jury - At ho tc. (Specify	me, ferm, stre	et, fectory, office		2	8f. Location (S City or Tow		er or Rura	Route Number,
	tal o												
	To the Hospital or Att within 24 hours efter of To the Funeral Direct completely filled in by	edicai	29e. Cartifier 1 ✓ Certifying Phye 2 ☐ Medical Examin	ler: On the basis of	of examinet	viedga, daath ion and/or Inv	occurred at the the	me, deta end opinion, deat	d place, a	nd dua to tha o	cause(s) end ma dete end plece.	nner as st	ated. the ceuse(s)
	To the H within 24 To the Fl complete	Med	une)	end mennar s	tated.								
	5 1 V 5 0		29b. Signetura and title of certifier	011			29c. Licans	sa number		1	29d. Data signe	u (Month, l	Jay, Tear)
	4		1 Min. neg	bala			Do	734	8		JUNE	16	1999
			30. Name and eddress of person who go	mpleted cause of			Print)	_			1. 20)		
			R. M. N. B. D. Z. D. A. L. A., 31. Dete filed (Month, Day, Year)	na 117		141283	TON RX	F.	: W	ISR M	N. 20)	44	
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VOID CERTIFICATE # 99-2/506. SEE

CERTIFICATE 99-20876



State of Maryland / Department of Health and Mental Hygiene 99

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								Cer	tificate (of L	Death	7		Reg. No.				
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	/Medi			od Fran							- Oh T		June	24,	199		7:30 A	M
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L			Cupper	tt-Week	s Nursi	ng Ho	ome					land			Garre	tt		
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	land		10e. Stete	10b. County			10c. City, To	wn or Lo	cation							10d	I. Inside City	Limits
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0	the residence of the re	E	1 Never Mer	ried 2 Merr	ied 1 🗌	Yes 2 X							rican, etc.)			Vhite, etc		
22	72 hours after death with the Manyand naturel; or items 23a or 28s-f show dical Examiner must be notified at	by	3 ☑ Widowed	4 Divorced	If Ye	es, Give or Detes:		1	1□ Yes 2Ã	No	Specify	:			Specify:	Whit	e	
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manjar Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified an once.		Carolyn	I. Hell	big/Dau	ghter							land, M					
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			23a. Pert1. Enter shock, or he	the disease, or art feilur . List	only one ceuse	thet cause on each I	d the deeth. Do Ine.	o not ente	er the mode of	dyln	g, such es	cardiac	or respiretory e	errest,		î	pproximete nterval Betwe	
8.	Physician															0	Inset and De	eth
	/Medical		Immediate Ceuse disease or conditi	(Finel	ath	eroso	lerotio	car	rdiovas	cu	lar d	disea	ase			1	year	
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	certificate be executed ding physicien end ise es the burial-transit	xar	Sequentially ilst co if eny, leeding to it cause. Enter Und	onditions,			Due to (or es	conseq	uenca of):									
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m	es that the death igned by the etter be deteched for t	Physicia		di														
o	b et et	ysi	Pert II. Other signi	ficent conditio	ns contributing	to death t	out not resulting	in the ur	nderlying caus	e give	en in Pert	I.	23b. Did	tobacco	use contrit	oute to ti	he cause of	death?
2	thet the by detect	듄	diabete	es mell:	itus ty	pe tw	o, chro	onic	renal	fa	ilur	e	1 🗆	Yes 2F	☑ No 3[Probe	bly 4 Ur	iknowr
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Ë	Physician: The this certificate ral director, pag	Be	25. Wes case refe exeminer?	rred to medical							28. Plec	e of Deet	th (Check only	one)				
_	2 0	P	1 ☐ Yes 2 ☐	KNo	Hospitei:	1 Inpati	ent 2 ER/C	Outpetien	t 3 DOA	Othe	9r: 4₩ N	ursing Ho	ome 5 Res	Idence 6	Other (Specify)		
Division of Vital Record	a Ph		27. Menner of Dee			Dete of Inju		. Time of	28c.	Injury			28d. Describe					
9	A Att	5	1 Neturel 2 Accident	5 Pendin Investig	9	(Month, De	y rear)	Injury	М		r Yes 2 □	No						
S	Attending or death. ector: After by the fune	Ca	3 Suicide	6 Could r	not be	Diace of In	jury - At home,	form etr	ant factors of	linn			28f. Location	Street and	Numbero	r Qurel F	Route Numbe	
2	il or Attending P i efter death. I Director: After t d in by the funer	Certification:	4 Homicide	determ	ined 200.	building, el	c. (Specify)	ioiii, olie	ser, rectory, or	IIVa			City or To	wn, Stete)	7,10,11,001,0	, ridiani	10010 1401100	
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	Hosp 24 hou Fune stely fi	edicai	29e. Certifier (Check only one)	1 ☑ Certifyin 2 ☐ Medicai I	Examiner: On t	the basis o	of my knowledg f examination a	ge, deeth ind/or inv	occurred et threatigetion, in r	ne tim	e, dete e pinion, de	nd placa, eth occur	and due to the red et the time,	cause(s)	end menne plece, end	er es stet due to th	ed. ne ceuse(s)	
	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral	Med	29b. Signeture end	title of cepifier	_	menner st	ateu.		29c. Lie	cense	number			29d. Date	e signed (N	fonth, Da	ay, Year)	
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			30. Neme end edd															
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J. Ca. 19

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2:26 PM Sophia Klatskin June 19 1999 4b. City, Town, or Location of Death 4c. County of Deeth /Medical 4e Facility Neme (If not Institution, give street end number) Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral Days Hours 1 □ M 2 💢 F Months 577-34-8293 Yrs. 89 Director Sept. 20,1909 Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show inotified at show 1 N Yes 2 No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? ò 10250 Westlake Dr. or Barns 23s. 20817 U.S.A. Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Meritel Stetus filed within 72 hours after Hygiens. ther than "natural", or its 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No Specify: Specify: à 3 Ø Widowed 4 □ Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 1 2 College (1-4or 5+) Admin. Assistant Federal Government permit. Pages 1 and 2 should be tiled Department of Health and Mental Hygid Important: If Item 27 is marked other I any Injury or other treamatic event. th 17 Father's Name (First Middle 1 ast) 18. Mother's Name (First, Middle, Maiden Surname) 88 Jacob Klatskin Zelda Fishman 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald Pressman / nephew 1009 Kennedy St. Falls Church, VA 22046 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition June 22 20c. Location - City or Town, Stete WBurlel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 1999 Olney, Maryland 22. Name and Address of Fecility Stein Hebrew Memorial Funeral Home 21. Signeti 232 Carroll Street, NW, Washington, DC 20012 23e. Pent. Enter the disease, or complications to a shield the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause or each line. Approximate Interval Between Onset end Death Immediate Cause (Finel disease or condition resulting in deeth) Examiner Diverticulitis Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last Due to (or es a consequence of): Due to (or es a consequence of):

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

Box 68760.

Records, P.O.

of Vital

CLARK
6-19-6 Division Physician/Medical Completed Be

physicien and the bunal-transit 2 or Attending

L_o Certification:

24 hours 6 Medicai completely To the Within 2 Registrar

Hospital

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Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29b. Signeture end title of certifier 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

A RAJVANSHI MD 121 Conquestional

5 Pending investigation

6 Could not be determined

29c. License number D37891

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

23b. Did tobacco use contribute to the cause of death?

3 Probably 4 Unknown

24b. Were autopsy lindings aveilable prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 ☐ Yes 2X No

2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

24a. Wes en eutopsy performed?

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

Rockylle MD 20852 #409

31. Date filed (Month, Day, Year) JUN 2 4 1999

25. Wes case referred to medical examiner?

1 ☐ Yes 2 No

27. Menner of Death

Netural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

2. Registrer's Signature

Hospitel: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of injury

28e. Plece of Injury - At home, tarm, street, factory, office building, etc. (Specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.

28e. Dete of Injury (Month, Dey Year)

100 F 1058 F 100 F

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Dey Month 12:40 PM 20 1999. Clarke Ε. June Adrienne 4b. City, Town, or Location of Deeth 4a Facility Nema (If not institution, give street end number) 4c. County of Death MONT SPRINGBROOK ADVENTIST NURSING HOME SILVER SPRING If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Pay, Year) 12/9/42 7. Age (In yrs. last birthdey) 56 yrs 9. Birthplace (Stete or Foreign 5. Sociel Security Number 1 M 2 X F Months Deys Hours WASH, DC 579-42-4770 Usuel Residance of Decedent 10d. Inside City Limits 10e. Stete 10b. County 10c. City, Town or Location 1 Yes 2 No N/A WASHINGTON 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? USA 20011 5817 5TH STREET NW 11. Maritel Status ** Single ** Wes Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Merried 1 Yes 2 No 13. Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Bleck, White, etc. BLACK If Yes, Give Yeer or Detes: 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedant's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE NONE NONE 18. Mother's Neme (First, Middle, Maidan Surname) 17. Fether's Neme (First, Middle, Last) DONZALETTA HARRIS PHILLIP A. CLARK 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Raietionship (Type, Print) 5817 5TH ST NW, DC 20011 GLORIA STUCKEY (COUSIN) 20b. Piece of Disposition (Neme of 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) ARLINGTON NATIONAL CEM 6/30/99 ARLINGTON, VA. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses John T. Rhines Company 3030 12th. St., N.E. Wash., D.C. 20017 23e. Prt1. Enter the diseese, or complications that caused tha daeth. Do not antar the mode of dying, such as cardiac or raspiretory errest, ock, or heart feilure. List only ona cause on each line. Approximata Intervai Between Onset end Death · ecoebovasenlas Immediate Cause (Final Accident disease or condition rasulting in daath) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated exacts) Due to (or es e consequence of) that initieted events resulting in deeth) Lest Dua to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Failus L 1 Yes 2 No 3 Probably 4 Unknown Congunital mental 24b. Wara autopsy findings eveilable prior to completion of cause of daeth? 24e. Was an autopsy performed? neta6dation 2 0 NO 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 28. Place of Daath (Chack only one) Hospitel: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Menneuof Death 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury at Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

death certificete be executed attending physician and for usa es the bunal-transit Box 68760. P.O. Division of Vital Records, page 2 cartificeta or Attending Physician: this funaral

Examiner Physician/Medicai þ Completed Be Certification: To

Physician

· /Medical

Examiner

DC

Directo

Funerai

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r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at

with the Maryland

filed within 72 hours after death

Hygiene.

other

permit. Pegas 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 is marked othe any injury or other treumatic event, DDGS.

Physician

Examiner

/Medical

Maryland 21215-0020

Baltimore,

24 hours efter death. filled in by Hospital To the turn 24. To the Fun. Medical

30. Nama and addrass of parson who complated cause of death (Itam 23a) (Type, Print)

29b. Signature and fittle of cartifier

3 ☐ Suicide

29e. Certifier

4 - Homicide

(Check only one)

32, Ragistrer's Signeture

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

ManuanMD

A. Spark

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and mannar es stated.

2 Medical Examiner: On the basis of axamination and/or investigetion, in my opinion, deeth occurred at tha time, data and pleca, and due to the cause(s) end menner stated.

29c. Licanse number

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Location (Street and Number or Rural Route Number, City or Town, State)

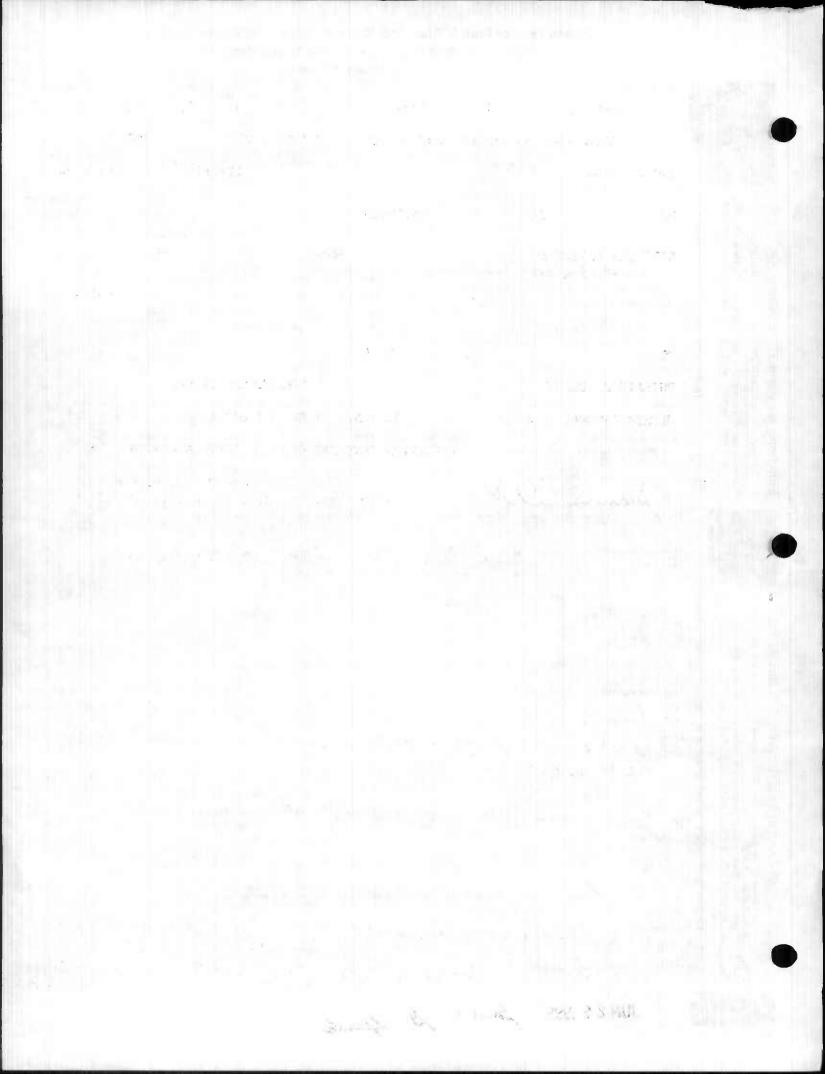
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29d. Date signed (Month, Dey, Year)

31. Dete filed (Month, Day, Year) JUN 2 3 1999 Registrar

6 Could not be determined

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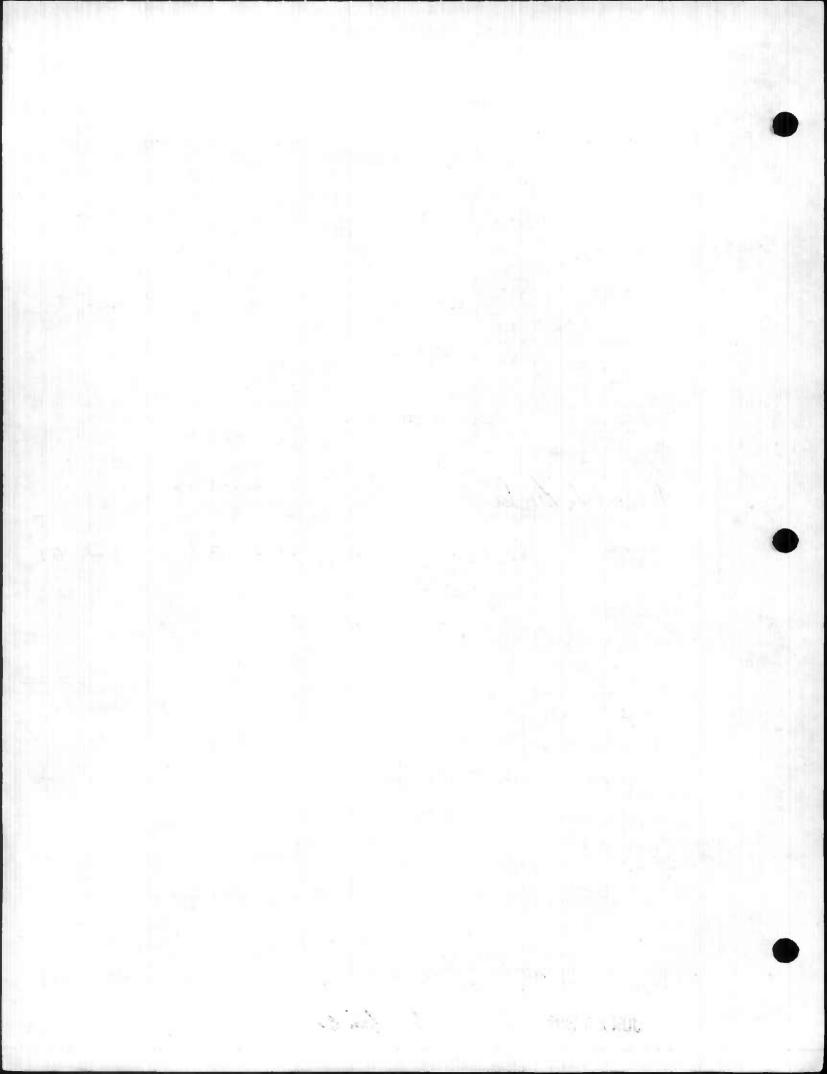


State of Maryland / Department of Health and Mental Hygiene

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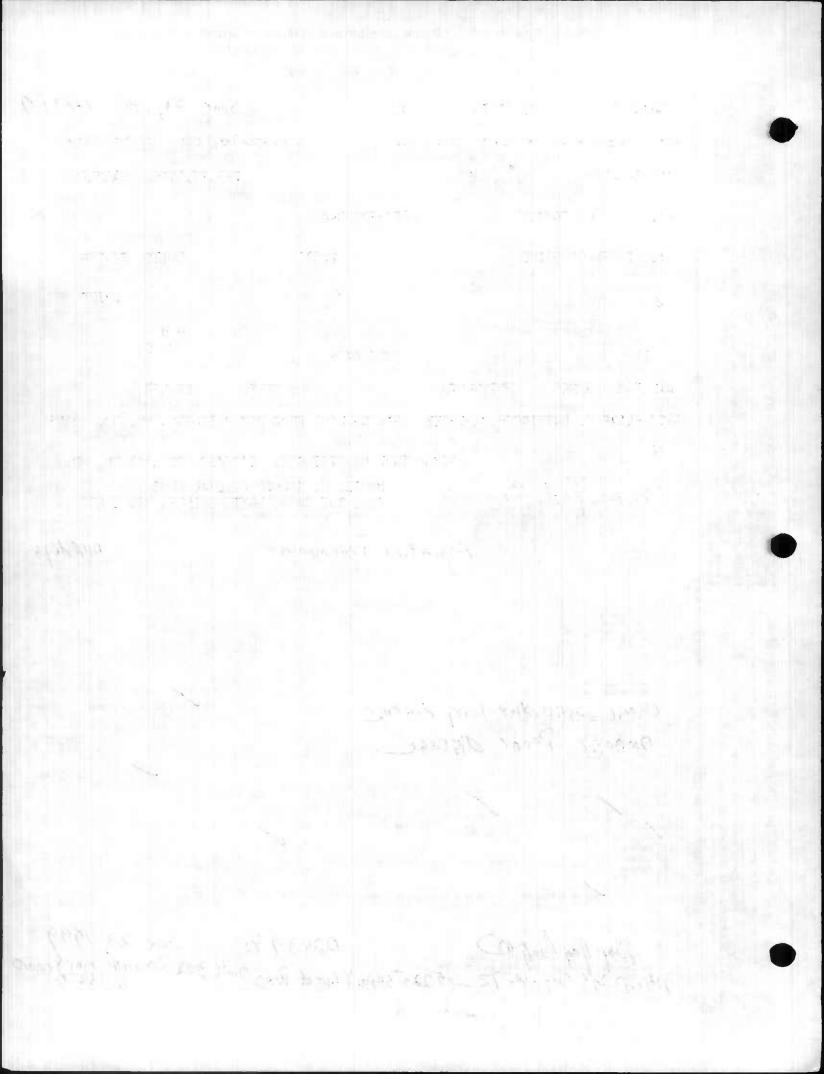
			Cei	tificate of	Death		Reg. No.	2	-1010
Physician /Medical	Decedent's Neme (First, Middle, La Irving	Clurman				2. Date of De Month	Dey 23	Year 1999	3. Time of Death 7:25 A.M.
Examiner	4a Facility Name (If not institution, given 2915 Blueberry	Separati neserate			4b. City, Town, or Bowie		4c. County	of Deeth	eorge's
uneral rector		Sex 7. Age (In yrs. 75	last birthday) Yrs.	If Under 1 Yea Months Days		(Month, Da	th ly, <i>Year)</i> 19, 1924		lace (State or Foreign try) York
notheral	10a. State 10b. County Maryland Prince		y, Town or Lo	cation				10	0d. tnside City Limits 1 Yes 2 No
Funeral Director	10e. Street and Number 2915 Blueberry Le	ane		10f. Zip Code 20715			10g. Citizen of V		•
by	11. Marital Status 1 Never Merried 3 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? to Yes 2 No If Yes, Give Year or Dates: WWI		Ves Decedent of I Yes, specify Cu I ☐ Yes 2 No	Hispanic Origin? (S ban, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Rac Ble Specify	wa - America ok, White, o	etc.
jeted	15, Decedent's E (Specify only highest gro		(Give	lent's Usual Occi kind of work don OO NOT use retir	e during most of wo	rking	16b. Kind of B	usiness/Ind	lustry
e Completed	Elementary/Secondery (0-12) 12 17. Father's Neme (First, Middle, Last	College (1-4or 5+)	Prin			me (First, Middle	G.P.O		
To Be	Samuel Clurman				Ida I	Klein			31E-1E-1
	19e. Informent's Neme/Relationship (Adele Clurman	Type, Print) Wife			et and Number or R				
eny Injury or other tr. once.	20e. Method of Disposition Burial 2 Cremetion 3 C 4 Donetion 5 Other (Specia	Removel from State	semetery, cren	sition (Name of natory or other pl n Nation	ace) July nal Cemet	l, 1999 ery	20c. Location -		wn, State irginia
Donce	21. Signeture of Funeral Service Lice	Eigle .			ress of Facility E. Evans I				0715
	23a. Part1. Enter the disease, or corr shock, or heart teilure. List only	plications thet caused the deat one cause on each line.							Approximete Intervel Between Onset end Deeth
lan cal ner	Immediate Cause (Finel disease or condition resulting in death)	e. Carona Due to (a	or as a conseq	arter	y dis	ease		1 1 3 1	20 YM
for use as the buriet-transit cian/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	. Hype	or as a consequence of a consequence of	sive	hear	fdis	Pasp		
ysicia	Pert II. Other algnificant conditions of	contributing to death but not res	ulting in the u	nderlying cause g	given in Pert I.	23b. Did	tobacco une co	ntribute to	the cause of death?
d be detached for us d by Physician/	Hyperten!	sion				10	Yes 2/2 No	3 Prot	bably 4 Unknown
2 should pleted	Diabete	5	1 -				an autopsy ormed?	ava con	ere eutopsy tindings ailable prior to mpletion of cause death?
rector, page 2 Be Comp	Ischemi	, heart o	lisea	se		10	Yes PUND	10	Yes 2 No
To Be	25. Was case reterred to medical examiner? 1 Yes 2 No	Hospitel:	ER/Outpatien	t 3D DOA	Whor	tome 5 Resi		er (Specifi	v)
ed in by the funeral Certification: T	27. Menner of Death 1 Natural 5 Pending 2 Accident Investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inj		28d. Describe	how injury occur	red	
	3 Suicide 6 Could not be determined		ome, farm, str	set, factory, office	В	28f. Location (City or To		per or Rure	il Route Number,
pletsly file	(Check only 2 Medical Examone)	nysician: To the best of my kno- niner: On the basis of examina and manner stated.	wiedge, death tion and/or inv	occurred at the restigation, in my	time, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) end medate end placa,	enner as st and due to	sted. the cause(s)
Med	29b. Signature and tale of certifier	7 Chillen	mo	29c. Licer	se number 503	2/	29d. Dete signe	d (Month, 1	Dey, Year)
	30. Name and address of person who	completed cause of death (Item	3 23a) (Type,	Print) Supe	erior La	A-6	Bowie	Md	20715
State Registrar	31 Date filed (Month, Day, Year)	32. Fliggistrar's Signa	iture &	1 .					

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				State of Ma		Department Certificate			Reg. No	22	21511
3	Physici /Medi Examir	cal	Decedent's Neme (First, Middle, Las DOROTHY Facility Name (If not institution, give	VIRGINIA	C	OLE	4b. City, 1	2. Dete Mor 20	19 23	y / 9 Year . County of Deeth	3. Time of Death 1227 PM
	Examili	ier	Shady Grove Adv		Hospit	al	Ro	ckville	, MD	Montgo	me ry
	Funeral Director		5. Social Security Number 215 26 0769 Usuel Residence of Decedent	7. Ag □ M 250 F	e (In yrs. last bir	Yrs. If Under Months	Year If Under Days Hours		of Birth oth, Dey, Year, .26,19		place (Stete or Foreign Intry) YLAND
	with the Maryland or 28a-f show be notified at	ctor	MD . 10b. County MD . MONTGON	1ERY	10c. City, Town	or Location AITHERSB	URG				10d. Inside City Limits 1 ☐ Yes 2 No
	or 28	Director	10a. Street and Number			10f. Zip				tizen of What Cou	
020	72 hours after death with the Maryland natural', or items 23e or 28e4 show yies Examine must be notified at	by Funeral	9200 EDGEWOOD DR	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	Ever in U,S.	13. Was Decede If Yes, speci	. /	Origin? (Specify Yes an, Puerto Rican, e y:		ITED STA 14. Raca - Amer Black, White Specify: WH	ican Indian,
1215-0020	within 72 hourship.	Completed by	15. Decedent's Edi (Specify only highest grad Etementary/Secondary (0-12)	ucation de com <i>pleted)</i> College (1-4or 5		Decedent's Usual (Give kind of work life. DO NOT use	k done during me e retired)	ost of working	OWI	Kind of Business/I N OME	ndustry
7 0	Hygi ther ont,	Be Co	17. Father's Neme (First, Middle, Last)	0		HOMEMAK		her's Name (First,			
Maryland	should be nd Mental marked o	ToB	WILLIAM JAMES	WHITWO	ORTH			HELEN	BEA	LER	
Mar	d 2 sho h and 7 is mu traum		JACQUELINE V. HOT					ber or Rurel Route			
Itimore,	Pages 1 annent of Healint: if Item 2		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removat from State	20b. Ptace of cemeter	Disposition (Nem y, cremetory or of	e of her piece)	Date	20c. L	ocation - City or 1	Town, State
Baltir	permit. Par Departmen Important: eny Injury		21. Signeture of Funeral Service Licen		er	MURIE	Address of Fed L H. BAI	RBER FUNE	RAL HO		
M	20.00		23a. Pert1. Enter the disaete, or comp shock, or heart failure. List only	lications that caused	the death. Do	P.O.	BOX 5038 of dying, such a	B, LAYTON as cardiac or raspir	SVILLE etory arrest,	. MD. 20	882 Approximeta Interval Between
	Physician /Medical Examiner		Immediata Ceusa (Finel disease or condition resulting in death)		Aspirat	iun Pr	eumani.	9			Onset and Death
	D S	ner			Due to (or es a	consequenca of):					
60,	e be executed sician and e bunal-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Dissess or Injury	0.	Due to (or es a	consequence of):					
289	death certificate b e attending physic od for usa as the b	Physician/Medical	that initiated events resulting in death) Lest	d	Due to (or as a	consequence of):					
. Box	d for us	Iclan	Part It. Other algnificant conditions co	ntributing to death b	ut not resulting i	tha underlying ca	use civen In Per	1 23	b. Did tobacc	o uaa contribute	to the cause of death?
, r.O.		by Phys		-							obably 4 Unknown
Hecords,	law requires that the as been signed by the 2 should be detach	Completed t	DIAPATIC P	punc o	liseage	2		24	e. Was en euto performed?	6	Wera autopsy findings evailabla prior to completion of cause of daath?
	The ate h	Con							1□ Yes 2	2 L3 No	Yes 2□ No
of Vital	Physicien: The law ribis certificate has be ral director, page 2 s	E To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manper of Deeth	Hospital:	rv 28b.		A Other: 4	Nursing Home 5			city)
DIVISION	Attending Is death.	Certification:	1 Naturat 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			m, street, factory	3c. Injury et Work? 1 ☐ Yes 21		ation (Street a	and Number or Ru	ral Route Number,
2	교육등등	I Cert	4 Homicide	building, et	c. (Specify)				to the cause		stated
	To the Hospital within 24 hours To the Funeral completely filled	edicai		Iner: On the basis o and manner st	f axamination an						
	Withi Within	Σ	29b. Signature end title of certifier	t-m)		29c	D243	99	29d. D	ete signed (Monti	1, Day, 3999
			30. Nama and address of person who of	completed cause of c	death (Itam 23a)	(Type, Print)	GROUP !	ROAD Suit	302	Zoch mile	MAI JEANS
	Sta Registi		31. Dete filed (Month, Day, Yaar) JUN 2 5 199	_	ar's Signature	5. lo	orks/				



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** JUNE 20,1999 BERNADETTE CAWLEY 1:00 AM /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BROOKE GROVE REHABILITATION CENTER SANDY SPRING MONTGOMERY If Under 1 Year Months Days 8. Dete of Birth (Month, Pay, Year) Sept. 12, 1910 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) **Funeral** 1 M 250 F Hours 170-10-0061 88 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Health and Mental Hygiene. In: If item 27 is marked other than "natural", or items 23a or 28a-f show mix if item 27 is marked other than "natural", or items 23a or 28a-f show mix if item 27 is marked other than "natural" or only ite Madeial Examiner man be notified at my or other than matter ovent, ite Madeial Examiner man be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Montgomery 1 ☐ Yes 2 BNo 01nev 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3704 Gelderland Court 20832 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 14. Race - American Indien, Bleck, White, etc. 11. Meritel Stetus Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specity: White Completed by Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Manager Retail Store 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Patrick Cawley Anna Downes 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Patricia C. Lydon/Sister 3704 Gelderland Court, Olney, Maryland 20b. Plece of Disposition (Name of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department o Important: If i any Injury or Metropolitan Crematory 6/21/99 Alexandria, Virginia 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerei Service Licanses 22. Name and Address of Facility
Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Maryland 20882 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart fellure. List only one cause on each line. **Physician** Immediate Cause (Finel disease or condition resulting In death) /Medical runousny OBSTRUGTU **Examiner** Due to (or es e consequence of) Physician/Medical Examiner sician end buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Lest Due to (or es e consequence of) physician s the burie Due to (or as e consequenca of): 80 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 ☐ No 3 Probably 4 Unknown As THERE PARTIN ATOLO by page 2 should 24b. Were autopsy findings Completed 24e. Wes en eutopsy evaileble prior to completion of cause of death? performed' 1 Yes 212 No 1 Yes 2 No 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred After or Attending 1 MNatural 5 Pending investigation 1 Yes 2 No To the Hospital or Attendil within 24 hours efter death. To the Funerel Director: A 2 Accident the 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 T Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) end manner steted.

346 emmuron

29c. License number

cours, suite 200,

29d. Dete signed (Month, Day, Year) JUNE 21,1999

20836

Box 68760, P.O. Division of Vital Records.

State Registrar

Medical

completely

29a. Certifier

(Check only

31. Dete filed (Month

29b. Signeture end title of certifie

JUN 23

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

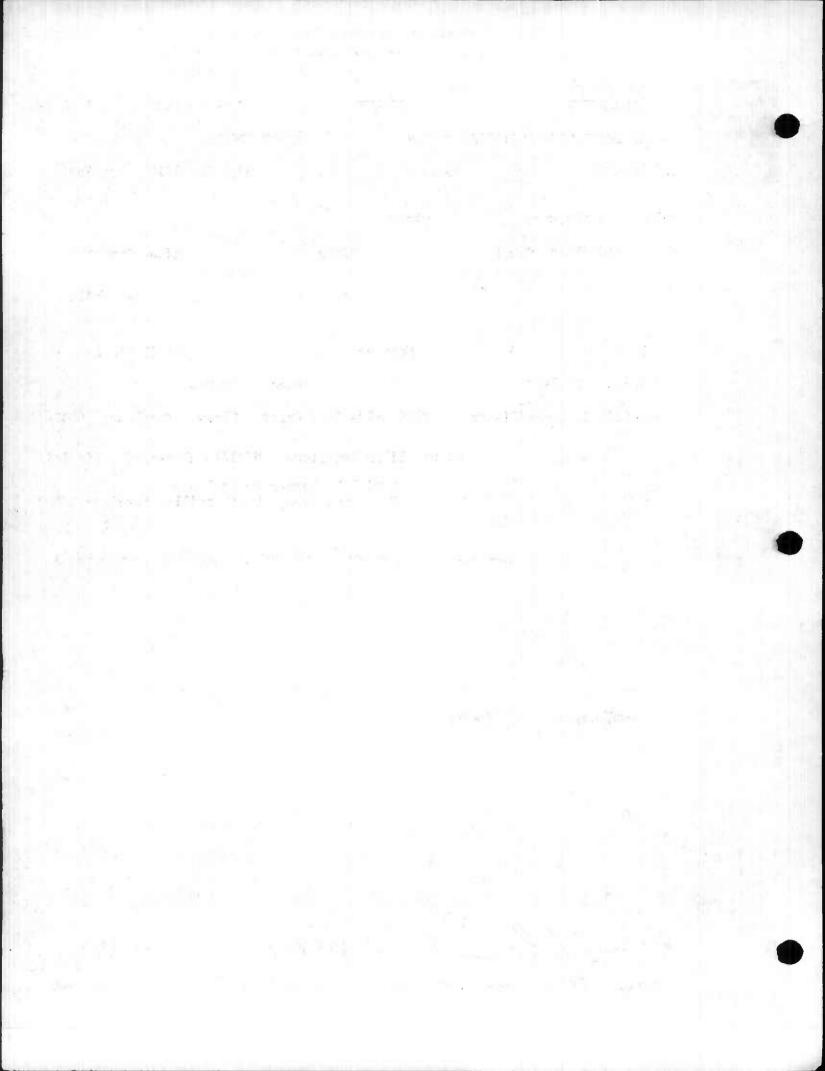
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32. Registrer's Signeture

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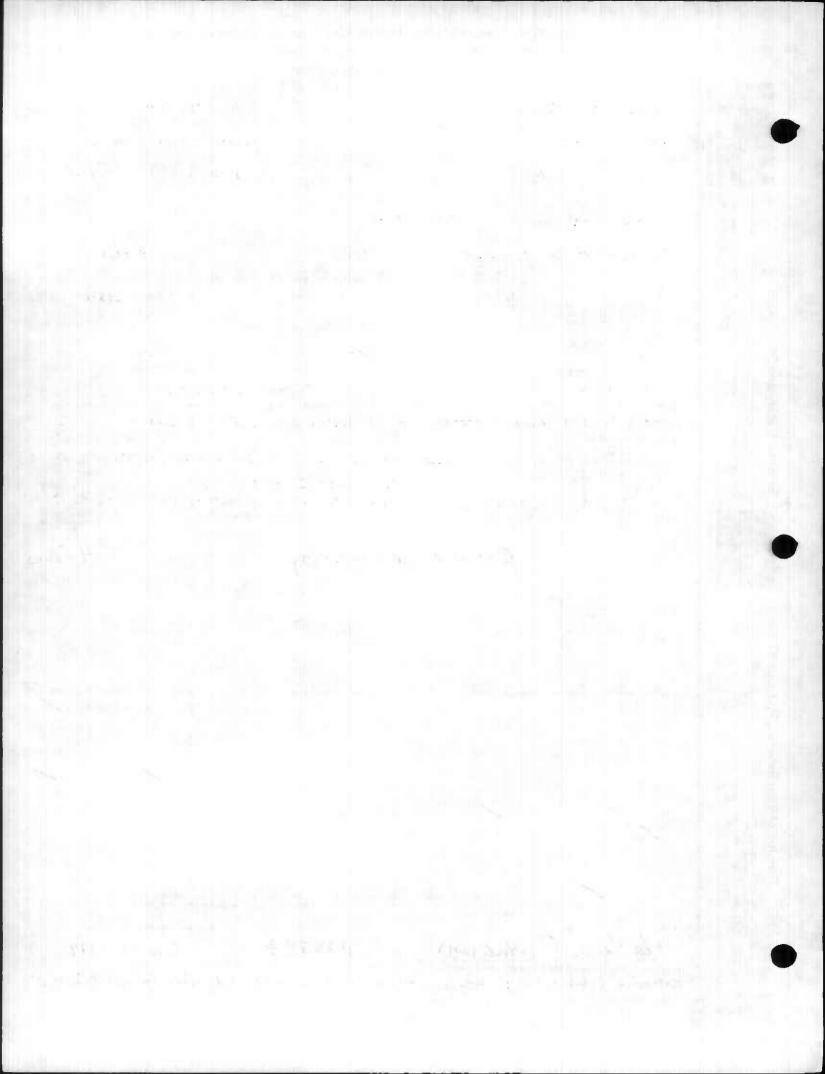
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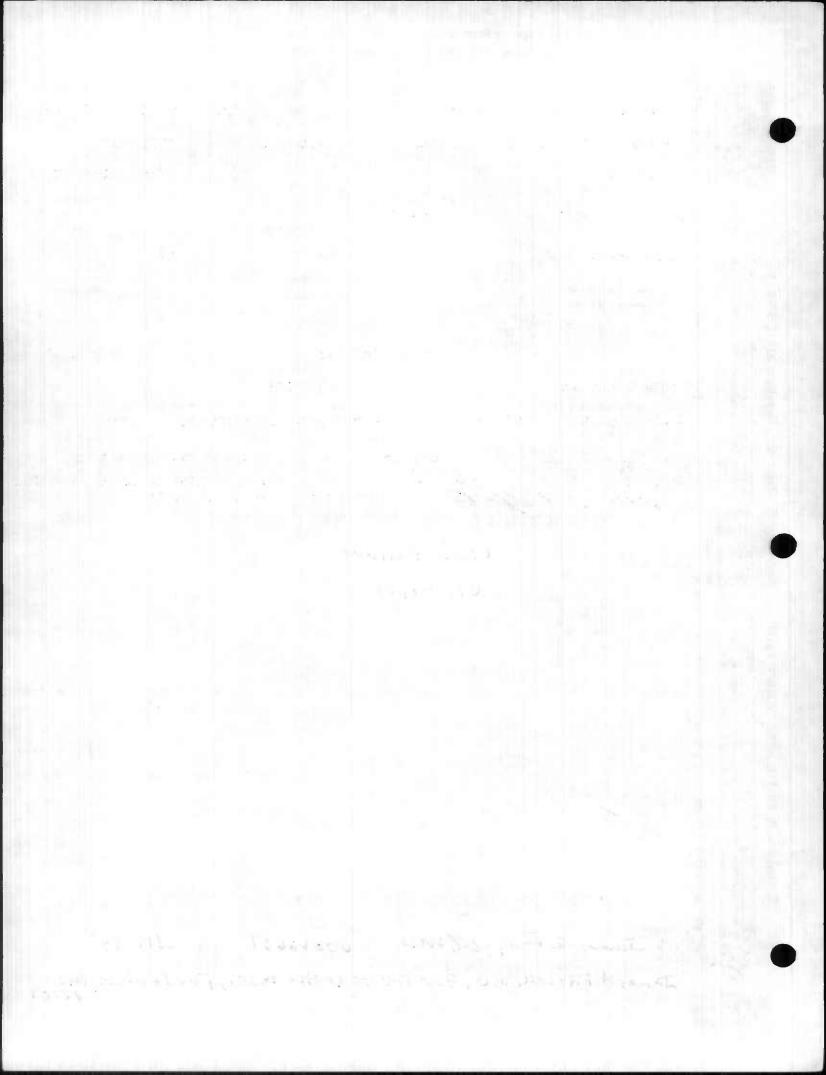
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			Ce	rtificat	e of	Death			Reg. No.			
	1. Decedent's Name (First, Middle,	Last)						2. Date of De	ath	Maria	3. Time o	of Death
Physician	Joseph Vinod C	havan						June 1	.8, 199	9 Year	6:0	5 AM
/Medical Examiner	4a Facility Name (If not institution,					4b. City, To	own, or Lo	ocation of Deat		nty of Death	-	J 1111
LAdminer	Holy Cross Hos	pital				Silve	r Sp	ring	Mon	tgome	rv	
Funeral	***************************************		(In yrs. last birthday			If Under	24 Hrs.	8. Date of Bir (Month, De		9. Birth	place (State	or Foreign
Director	none	1₩ 2□ F	Yrs.	Months	Days	Hours 3	58	June 1	8, 1999		yland	
· · · · · · · · · · · · · · · · · · ·	Usual Residence of Decedent											
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eeth with ma 23a o	1909 Winexburg C	ourt, #T-2		209	906				Unite	d Stat	tes	
	11. Marital Status	12. Was Decedent E Armed Forces?	ver In U,S. 13.	Was Deced	dant of I	Hispanic Or	igin? (Spe	ecify Yes or No Rican, etc.)		Raca - Ameri Black, Whita		
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and 2 be filed that Hygical Arter event, the	17. Father's Name (First, Middle, La	st)				18. Moth	ar's Name	a (First, Middla	, Maidan Surr	eme)		
ylan ould be Mental I arked of artic eve	Vinod G. Chavan					Kalp	ana '	V. Khan	dagle			
Maryls d 2 should th end Mer 7 is merke traumetic	19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ing Address	(Stree			al Route Numb		wn, Stete, Zi	ip Code)	
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ore, No. 1 and of Health item 27 other tr	20a. Mathod of Disposition		20b. Place of Disp cemetery, cre	osition (Nen	ne of			Date	20c. Locatio			
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르 교원관광 .	21. Signature of Funeral Servica Llo							ces, P.		,	11012	
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Physician	Immediate Cause (Final		,		,					1		
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No the composition of the compos	29b. Signature and title of certifier			290	c. Licen	se number			29d. Date sig	ned (Month	, Day, Year)	
	Wither !	- lash it	m	7	72	873	7		Time	18	1999	
	20 Name and address of name of	-V mul	oth (Itom CCs) (T	Print'					JUNE	10,	117	
	30. Nama and addrass of person who Katherine C. Whit	e, M.D. Hol	y Cross Hosp	1tol, 1:	500	Forest	r Gle	n Rd, S	ilversp	ring P	10200	910
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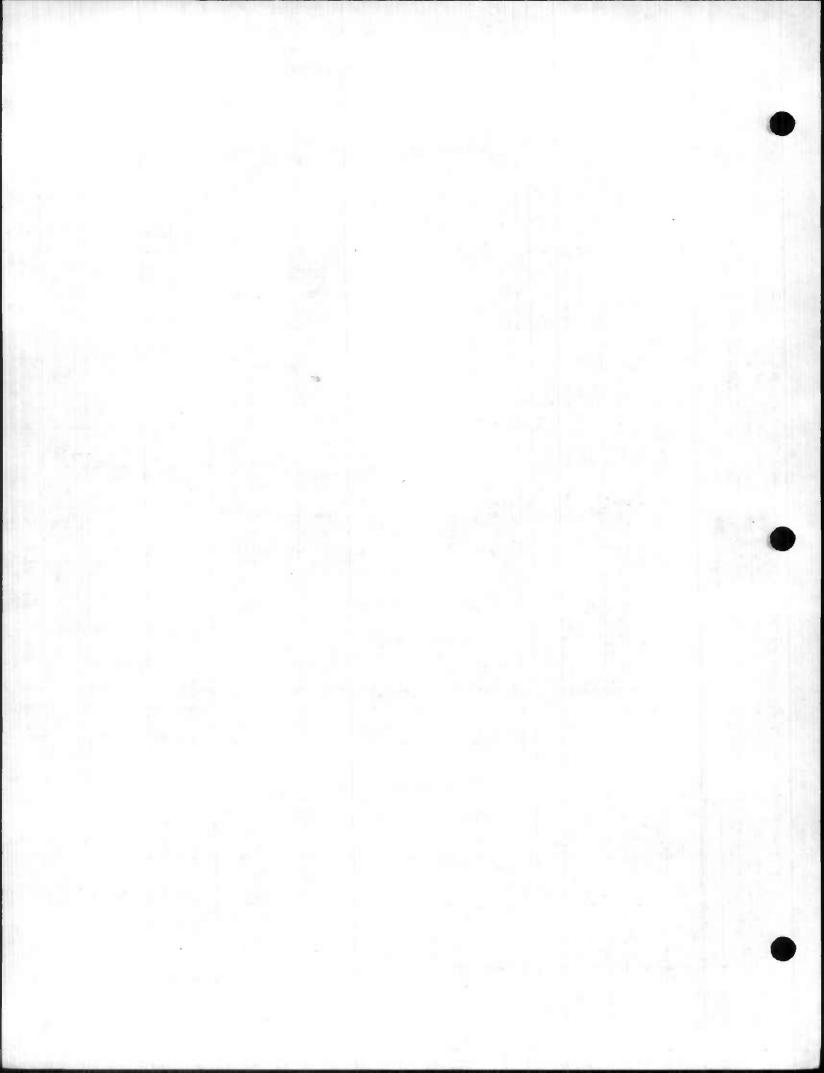
						Ce	rtificat	e of	Death)		Reg. No.		-1019
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	Physician	Pame1a	М.		Clark						June	18 1	999	7:20 PM
4	/Medical Examiner	4a Facility Neme (If n		e street and nu					4b. City, To	own, or Lo	ocation of Dea	7	y of Deeth	7.20 111
	Examino	FREDERICK	MEMORIA	AL HOSP	ITAL. I	NC.			FREDE	RICK		FRED	ERICK	
	Funeral Director	5. Sociel Security Num 085-42-254	nber 6. S		7. Age (In yrs		Months		If Under	24 Hrs. Min.	8. Dete of Bi (Month, D		9. Birthp	place (Stete or Foreign entry) INSYLVANIA
	9	Usuel Residence of D	ecedent										· ·	
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20	within 72 hours after death with the Maryland ene. than "naturel", or items 23s or 28s-f show its Modical Exerciting routility in Modical Exerciting routility in Modical Exerciting Interest in Director	11. Maritel Status 1 Never Merried		Armed For 1 Tyes If Yes, Gi	2) No	J,S. 13.	Wes Deced If Yes, spec	cify Cub	oan, Mexica	n, Puerto	ecify Yes or N Rican, etc.)	Bie	ce - Americ eck, White, by: WHI	etc.
8	"naturel", or police Exercised by F	3 ☐ Widowed 4		Yeer or E	Detes:	16a Door	dentie Heur	al Occur	nation			16b. Kind of E	2.uelnoce/in	duetes
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212	with the the	Elementery/Second	ery (0-12)	Coilege (1-4or 5+)		ECHNI					CHEM	TCAL/	MEDICAL
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Maryland	Bad a	EDWARD D.	CLARK						HEL	EN S	INEY			
ary	2 should and Men is marke aumatic	19a. Informent's Nam	e/Reletionship (Type, Print)		19b. Maii	ing Address	(Stree	t and Numb	er or Rur	ral Route Numi	ber, City or Town	, State, Zij	Code)
	alth ar 27 is r trau	KAREN DUNN	ING	(SISTE	R)	451	HATBO	RO	ROAD	CHU	RCHVILI	E, PA	18966	5
ore,	of He oth	20a. Method of Dispos				Plece of Disp cemetery, cre	osition (Ner	ne of	ace)		Dete	20c. Location	- City or To	own, Stete
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra once.	1 X Burial 2 ☐ 4 ☐ Donation 5			State	ISET ME				6.	-23-99	FEASTER	VILLE	, PA
alti	Departin Departin Importa any inju	21 Signeture of Fune	rel Service Licer	1588		7 2	2. Neme en	nd Addr	ess of Fecil	ityHTN	ES-RINA	LDT 118	OO NE	W HAMPSHIR
B	88188	1 660	25	Mell	10						ING, MI			
?		23a. Pert1. Enter the shock, or heart	diseese, or com	plications that	ceused the dee	th. Do not er	iter the mod	le of dy	ing, such es	s cerdiec	or respiretory	errest,		Approximete Intervel Between
	Physician		,											Onaet end Deeth
ч	/Medical	Immediate Cause (Findisease or condition	nel		Liver	Fai	100	<					1	
П	Examiner	resulting in death)		θ		or es e conse							1	
-	P # G		_	b	Cirr	4051	5							
,00	death certificate be associted attending physician and id for use as the bunat-transit iclary/Medical Examiner	Sequentially list cond if eny, leeding to Imm ceuse. Enter Underly Cause (Disease or Injustical August 1981)	itions, ediate	0.	Due to	or es e conse	quence of):							1, 11, 12, 2
68760,	ficate be physicie is the bu	that initieted events resulting in deeth) Le		G.	Due to (or es a conse	quence of):						i	
×	ding passes as		L	d.								-	i	
Bo	at the death of the attenders of the attenders of the the the of the use of the the the the the the the the the the			-										
0	0 0 0	Pert II. Other significa	ant conditions o	ontributing to d	leath but not re	sulting in the	underlying c	euse g	iven In Part	1.				to the cause of death?
0	es that the igned by the be detach by Phy										1	Yss 2 No	3 Pro	bably 4 Unknown
Records,	requires that the een signed by the hould be detache sted by Physesecker										24e. Wa	s an eutopsy		ere autopsy findings
03												formed?	CC	velleble prior to ompletion of cause i death?
Re	The law ata has be page 2 s											Iv- a Delle		
a	certificata rector, par	25. Wes cese referred	d to madical						22.21	4.5		Yes 2 No		☐ Yes 2☐ No
Vital		exeminer?		Hospital:	Martinet Of	TER/Outertie		01	ther:		th (Check only		than (Casa)	241
of	2 2 2	27. Menner of Deeth		28e. Dete	of injury	28b. Time		28c. Inju		ursing ric		sidence 8 00 how Injury occu		19)
on	leath. for: After the funer cation	1 Naturei 2 Accident	5 Pending Investigation		nth, Dey Year)	Injury	М		ork?]Yes 2.[No				
Division	tal or Attending P is after death. al Director: After t led in by the funers Certification:	3 Suicide	8 Could not b	288. PIBC	e of Injury - At I	nome, ferm, s	treet, fectory	y, office					ber or Rur	rel Route Number,
ā	afte afte	4 Homicide		build	ing, etc. (Spec	ily)					City or 10	own, Stete)		
	To the Heapital or Attendwithin 24 hours after death within 24 hours after death completely filled in by the Medical Certificat	29a. Certifier 1 (Check only 2)	Cartifying Ph	ninar: On the b	e best of my kn easis of examin	owledge, dee ation and/or i	th occurred nvestigation	et the t	ime, date e opinion, de	nd pleca, ath occur	and due to the red at the time	e ceuse(s) and n	nenner es s , and due t	steted. to the ceuse(a)
	Nethin Sompl	29b. Signeture end titl	le of certifier				290	c. Licen	se number			29d. Dete sign	ed (Month,	Dey, Year)
		1 Jan	res A-	+in	Jelle 1	MD	1	00	0166	637		6/19	199	
	20				4								•	
	(5)	Janesh	Prizz	ell, m	D, 9	15 Tol	1 400	15e	Ave	共2	01, F	vedeu	ick	, md
	State Registrar	31. Dete filed (Month,	1 2 1 199	39	Separa Sign	B .	pp	ack	2					



State of Maryland / Department of Health and Mental Hygiene O O

			State of IV	iai yiai ic			of Death	Neritai riyg	eg. No.	3 21	515
	61	1. Decedent's Nama (First, Middle, La	ist)					2. Data of Dea Month	th Dey	Year	3. Tima of Death
	Physician /Medical	Elvira	De			Correa		June 18	3, 1999	Toat	1:30 p.m.
	Examiner	4a Facility Name (If not institution, give	re street end number)			4b. City, Town, o	r Location of Death	4c. County	of Death	
		10250 Westlake	Drive, #5	15			Bethesda	1	Montg	omery	
	Funeral Director	134-66-2793	Sex 7. A 1□M 2∑0 F	ge (In yrs. le 83	est birthday) Yrs.	If Under 1 Y Months D	ear If Under 24 Hr ays Hours Mir		Year) 1915	9. Birthplace Country) Colomb	e (State or Foreign 1a
	the Maryland 28a-f show notified at ector	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	ation					Inside City Limits
	or 28a-7 be notified Director	Maryland Montgom	ery	Beth	nesda						1□Yes 2⊠No
	With the	10e. Street and Number				10f. Zip Co		1	0g. Citizen of \		
	E 23 E	10250 Westlake Dr	ive, #515			2081	7		United	States	5
	illed within 72 hours after death with the Maryles Hypiene. Hypiene in the fine free than "natural", or thems 23e or 28e-f show first that Medical Examiner must be notified at ent, the Medical Examiner must be notified at ent, the Medical Examiner must be notified at ent.	11. Marital Status 1 Never Married 2 Married 3 🖫 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 1 If Yes, Give Yaar or Datas:	Ever in U,S ? No			of Hispanic Origin? (Cuban, Mexican, Pue No Specify: Co		Blac	ce - American ck, Whita, etc. y: White	
Maryland 21215-0020	ad within 72 ho lygiene. Wer than "naturi it, the Medical. Completed	15. Decedent's E (Specify only highest gra	ade completed)		(Give k	ent's Usual O ind of work d O NOT use n	one during most of w	orking	16b. Kind of Bi	usiness/indusi	lry
212	iere. iere. ibe Man	Elementery/Secondery (0-12)	College (1-4or	5+)		memake			Own Ho	me	
0	THE O	17. Fathar'a Nama (First, Middla, Last)				18. Mother's N	eme (First, Middle, I	Maiden Sumen	ne)	19411
lan	Mental H ented off affic ever To Be	Hector Martinez					Lucila	Baena			
ary.	z should by and Menta is marked raumatic ev	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing	Address (St	reet and Number or I		City or Town,	State, Zip Co	ode)
ž.	4 4 4 4	Mayra Correa Mye:		er)			ourt, Pot			20854	
re,	-466	20s. Method of Disposition		20b. Pla	ace of Dispos	ition (Neme o	1	Date	20c. Location -	City or Town,	, State
٩	ragas nart of h	1 Burial 2 Cramation 3 C 4 Donation 5 Other (Special	Removal from State		sapeak			6-21-99 H	Reltsvi	11e. Ma	arvland
Baltimore,	ermit. Page Separtment of mportant: If iny Injury or ince.	21. Signature of Funeral Service Licer		Offe	-		idress of Facility	0 21 33	,010011.	110, 11	
ã	2011	Ca. 0 a	20		Ra	pp Fun	eral Servi				
	_	23a. Part1. Enter the disease, or com shock, or heart failure. List only	unlications that cause	d the death	93	3 Gist	Avenue, S	Silver Spi	ring, M		O oproximate
E	Medical Examiner	fmmediate Ceuse (Finel disease or condition resulting in death)	a. Arteri		rotic es e consequ		vascular 1	Disease			nset and Death
6	incate be assouted 1 physician and 1s the bunkl-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying	b	Due to (or	as a consequ	ence of):					
68760,	hysiciar the buni	Cause. Enter Undartying Cause (Disease or injury that initiated events rasulting in death) Last	c	Due to (or	as e consequ	ence of):					
	2 0 6 2	L	d						- 18		
0	d for all	Part fl. Other afgnificant conditions of	ontributing to death	out not resul	ting in the un	deriving caus	a given in Pert I.	23b. Did to	obacco use co	ntribute to th	e cause of death?
P.O.	es trat me death centing igned by the attending be detached for use as by Physician/Me	Bronchial Asthm	_					1 🗆 Y	ea 2⊠ No	3 Probab	oly 4 🗆 Unknown
Division of Vital Records,	been s should	(max production of the control of th						24a. Was e perfor		availa	autopsy findings ble prior to letion of cause
e g	ate has b page 2 s							1□ ∀	es 2X No		es 2□No
a	certificate rector, par	25. Was case referred to medical					26 Place of D	eeth (Check only or			
of Vita	0 TO	examiner? 1 X Yes 2 No	Hospital:	ent 2 🗆 E	R/Outpatient	3□ DOA	04	Home 5 Reside		ner (Specify)	
0	erthie eral	27. Manner of Death	28a. Date of Inj	ury :	28b. Time of		Injury at Work?	28d. Describe h			
0	ato effor	1 Natural 5 Pending 2 Accident Invastigation	(Month, Da	ay rear)	Injury	М	1 Yes 2 No				
Divis	which is a needed of the complete of the completely filled in by the funeral completely filled in by the funeral of the completely filled in by the funeral of the completely filled in the funeral of the completely filled in by the funeral of the completely filled in by the funeral of the completely filled in the complet	3 Suicide 6 Could not b 4 Homicide determined	286. Piece of in	jury - At hon tc. (Specify)		et, factory, of	ice	28f. Location (Si City or Town	treet end Numb n, Stete)	ber or Rural R	oute Number,
1	n 24 houns to Funer plettely fill edical	29s. Certifier 1 Certifying Ph	yalcian: To the best niner: On the basis of and manner s	of examinetic	ledge, death on and/or inve	occurred at the estigation, in r	e time, date end plan ny opinion, deeth oc	ce, and due to the courred at the time, d	ause(s) and ma ate and place,	anner as state and due to the	d. e cause(s)
4	To the	29b. Signal ureland title of certifier				29c. Li	ense number	2	9d. Date signe	d (Month, Day	y, Year)
	(6)	· W	_			D15	236		June 18	3, 1999	
		30. Name and address of person who					n 1 .	11. 35	1 1 1	00050	
		Carl I. Margolis				le Pil	e, Rockvi	ile, Mary	rand 2	20852	
	State	31. Date filed (Month, Day, Year)		rer's Signatu	ure /	1					

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 5:10 AM TOHN JOSEPH CURLING 1999 JUNE /Medical 4a Facility Neme (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17105 Interlachen Drive #1021 Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 4, 1920 5. Sociel Security Number Birthplaca (State or Foreign Country)
 DC 7. Age (In yrs. last birthday) **Funeral** Days Months 577-12-2136 12 M 2□ F 79 Yrs. Director Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show 1 ☐ Yas 2 ☐ No Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 눔 17105 Interlachen Drive #1021 Merrie 23a 20906 USA Funeral 12. Wes Decedent Ever in U,S.
Amed Forces?
1 □X/es 2 □ No
If Yes, Give
Yeer or Detes: 1942-45 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Merried Specify: White natural, or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. other then College (1-4or 5+) Elementary/Secondery (0-12) Mechanic Elevator Industry 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be i Department of Health and Mental Important: If Item 27 is marked or any Injury or other traumatic eve Claude Curling Mary Curling 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Jack Curling/ Son 833 Diamond Drive, Gaithersburg, MD 20878 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e Method of Disposition Jun 28 20c. Location - City or Town, State 1 Suriel 2 □ Cremetion 3 □ Removel from State MD Veteran's Cemetery 1999 Cheltenham, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc 500 Univerisity Blvd. W, Silver Spring, MD 20901 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock of heart feiture. List only one cellule on each line. Approximate Intervet Between Onset and Deeth **Physician** dispulmonany annest to consequence of): tastatic prostate cancinoma Immediate Cause (Final disease or condition resulting in death) /Medical Examiner certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest Box 68760 Physician/Medicai Due to (or as a consequence of): 80 The law requires that the death P.O. | Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an eutopsy 2 KNO 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

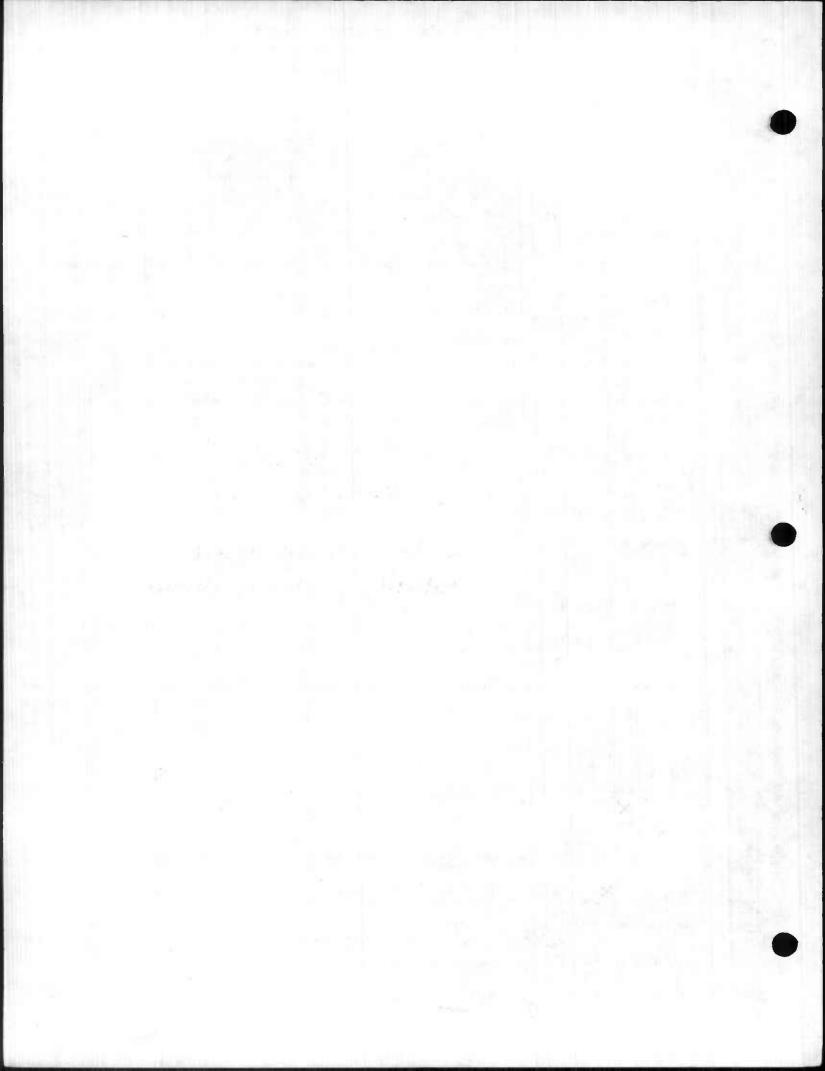
To the Funeral Director: After this certifica completely filled in by the funeral director; p 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) edicai Certification: To 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Death 28d. Describe how injury occurred 28b. Time of Netural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number 15 June 23, 1999 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Said Baidas, ,MD 1396 Piccard Drive, Rockville, MD 20850 301-721-6660 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State

DHMH 16 Rav 6/95

Registrar

JUN 25 1999



 The contract of the contract o	3		
State of Maryland / Department of Health and Mental Hygiene			
Certificate of Death	2 2	£ 1	U

	1.	Decedent's	Name	(First, A	Aiddle, Last)	
Physician /Medical		JACK	JEF	ROME	DAVIS	3	
Examiner	4a	a Facility Name (If not institution, give :					

JACK JEROME DAVIS JR.

JACK JEROME DAVIS, JR. 4a Facility Name (If not institution, give street and number)

JUNE 4b. City, Town, or Location of Death 3. Tima of Death 0135 AM

Funeral Director

ahow.

28a-f

b 238

Herman,

"natural", or

Pages 1 and 2 should be the ment of Health and Mental H lant: If Item 27 is marked off

Department of Health important: If Item 27 is any injury or other tra

72 hours after

Baltimore, Maryland 21215-0020

Director

Funeral

à

Completed

8

075-50-0230

ROUTE#50 AT #295

XXM 2DF Months 43

7. Age (In yrs. last birthday)

If Under 24 Hrs. If Under 1 Year Days Hours

CHEVERLY

PRINCE GEORGES

Year

Usual Residence of Decedent

5. Social Security Number

Prince George's

Bowie

8. Date of Birth Month, Day, Year! May 6, 1956

2. Date of Death

Month

 Birthplace (State or Foreign Country) New York

> 10d. tnside City Limits 1 No 2 No

10a State 10b. County

Maryland

10c. City. Town or Location

10f. Zip Code

10g. Citizen of What Country? U.S.A.

10e. Street and Number 13936 Heatherstone Drive

1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1979 1 1 1 1 2 2 1 No If Yes, Give Year or Dates: 1983 1979 1983

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Day

22, 1999

4c. County of Death

Black 16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grade completed) Eiementary/Secondary (0-12)

College (1-4or 5+) 4 years 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

17. Father's Name (First, Middle, Last)

Network Engineer 18. Mother's Neme (First, Middle, Maiden Surname)

Government

Jack Jerome Davis, Sr.

Dolores Jennings

20720

19a, Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 13936 Heatherstone Drive, Bowie, Maryland 20720

Sandra Davis/Wife

20a. Method of Disposity 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donayon 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State

Maryland Veterans Cemetery

Date 06/29 1999 Cheltenham, Maryland

21. Signature of Faneral Service Lig.

22. Name and Address of Facility J.B. JENKINS FUNERAL HOME

7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Ceuse (Finel

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

edicai

Physician /Medical Examiner

physician and the burial-transit

The law requires that the death certificate be executed

Box 68760,

P.O.

Records,

Division of Vital or Attending Physician: Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

disease or condition resulting in death)

LUUTIRGE Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy tindings available prior to completion of cause of death?

19 183 2 No

26. Place of Death (Check only one)

1 Yes 2 No

25. Was case reterred to medical examiner? NOXYes 2 No

27. Menner of Death

1 Natural

2 Accident

3 Sulcide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year) 28b. Time of Injury 6-22-99 01:29

Other: 4 Nursing Home 5 Residence 6 NOther (Specify) AT SCENE 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 1 Yes 2 ₽No

28d. Describe how injury occurred ON SECTE OUTCOUNTER DRIVER OF COST, MPRET WITH FIXE

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State) RT50+295 PRINCE GODINESCO, MD

29a, Certifier (Check only

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year) JUNE 22, 1999

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Konn

Hospital:

MARGO RITO 31. Date filed (Month, Day, Year)

JUN 2 4 1999

32. Registrar's Signature

un

fonds

Registrar **DHMH 16 Rev 6/95**

State

Affer

death.

24 hours after deal Funeral Director:

within 2 ŝ

Hospital

filled in

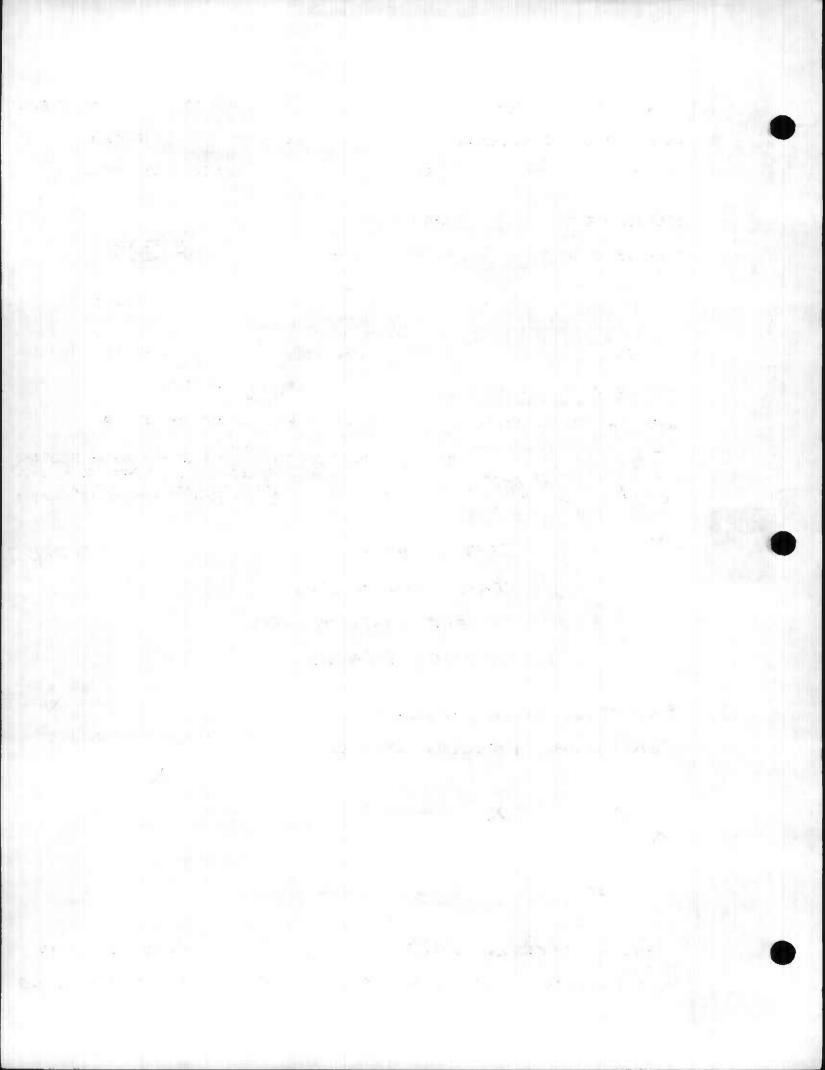
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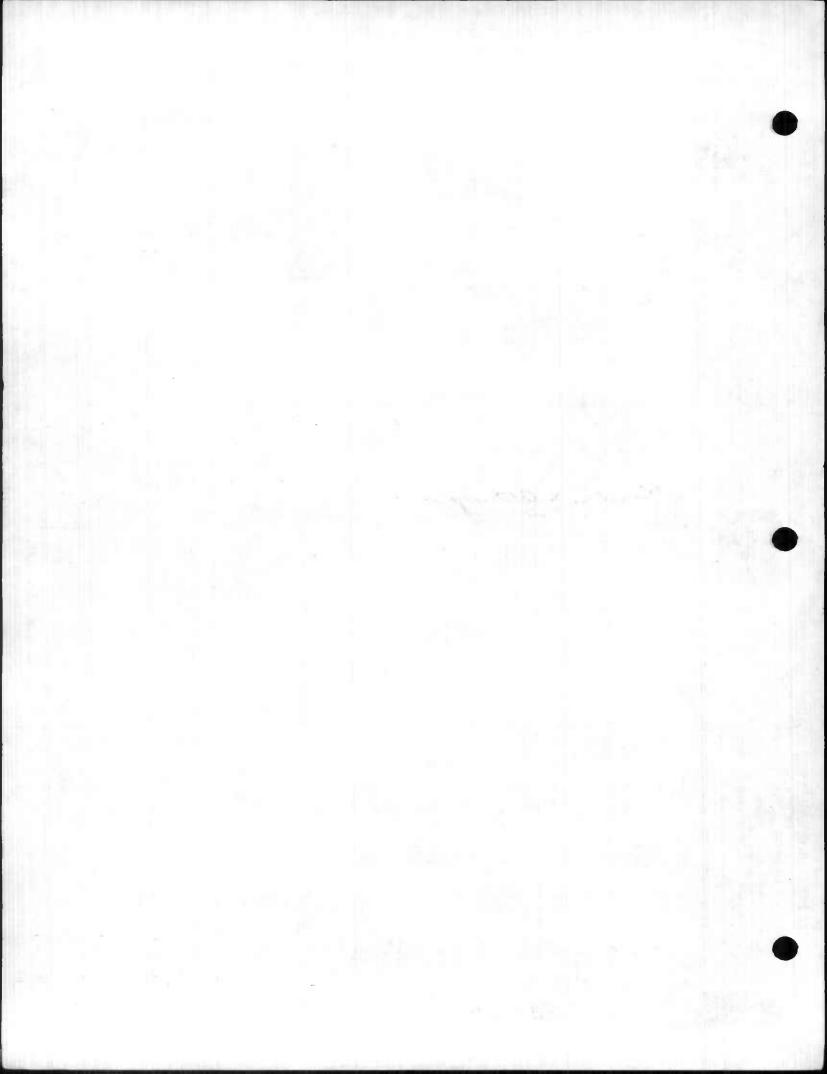
		State of Mary		tificate of			Reg. No.	4	518	
hysician	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Dey	Year	3. Time of Death	
Medical xaminer	NICHOLAS DEMITRIOS 4a Fecility Name (If not Institution, give st				4b. City, Town, or Lo	JUNE 18th, 1999 9:17			9:17 A.M.	
LAdiiiiici	WASHINGTON ADEVENT	ST HOSPITA	AL		TAKOMA PA	RK	MONTO	GOMER	Y	
neral ector	5. Social Security Number 6. Sex 1KD	7. Age (li	yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day MAY 10	v, Year)	9. Birthple Count GREE	ace (State or Foreign (ry) CE	
	Usual Residence of Decedent	1								
	10a. State 10b. County	10	c. City, Town or Lo	cation				10	od. Inside City Limits ▼ Yes 2 □ No	
or 28a-f show be notified at Director	MARYLAND FREDERICK 10e. Street and Number		FREDERICK	10f. Zip Code			10g. Citizen of V	What Count	****	
			21702			UNITED :	STATE			
Hygiane. the than "naturel", or items 23s or 28s-f show ent, tra Medical Exeminer must be notified at	1789 HARVEST DRIVE				Hispanic Origin? (Specify Yes or Noban, Mexican, Puerto Rican, etc.)		OF AMERICA No- 14. Rece - American India			
	1 Never Married 2014 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes XM No If Yes, Give Year or Dates:		☐ Yes XIX No		Hican, etc.)	Specify	k, White, 6		
2000		15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupetion (Give kind of work done during most of working				lustry	
Hygiane. wher than "nature ent, or Medical e Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	+) life. DO NOT use retired)							
	17. Father's Name (First, Middle, Last)			CHEF	18. Mother's Name	(First, Middle	RESTAU!			
1	DEMITRIOS NICHOLAS	DECLIDEC				MARINA J. MITILINEOU				
0	19e. Informent's Neme/Reletionship (Typ		19b. Meilin	g Address (Stree	t and Number or Rura			Stete, Zip	Code)	
	NORMA JEAN DEOUDES	(WIFE)	1789	HARVEST	DRIVE FRE	DERICK	MARYLAN	D 217	02	
	20a. Method of Disposition 1.	2	20b. Place of Dispo cemetery, cren	sition (Name of natory or other pla	ace)	UN.22,	20c. Location -	City or To	wn, State	
	4 □ Donation 5 □ Other (Specify)		GATE OF H		EMETERY	1999			G MARYLAND HOME, INC.	
	233 Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition		death. Do not ente		STLV ing, such es cardiac o	ER SPRI	NG MARY	LAND	Approximate Interval Between Onset and Death	
	resulting in death) a.		to (or as a conseq						201142	
Examiner	a b.	PERFO	RATED	UISC	us					
	Sequentially list conditions, if any, leading to immediate									
3	Cause (Disease or injury that initiated events C. SEVERE CARDIOMYOPATHY Due to (or as a consequence of):									
Physician/Medical	resulting in death) Last	AORT		TENOS	15					
	Part II. Other significant conditions conti	ributing to death but no	ot resulting in the ur	nderlying cause g	iven In Part I.	23b. Dld 1	lobacco use co	ntribute to	the cause of death?	
Dy Phy	END STAGE RENAL DISEASE				1 Yes 2 No 3 Probably 4 Unknown					
Completed	PERIPHERAL VASCULAR DISEASE 24e. Was en eutopsy performed?						ave	ere autopsy findings eilable prior to mpletion of cause death?		
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000	25. Wes case referred to medical examiner?				26. Place of Deat	n (Check only o	ne)			
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at Director: After this led in by the funaral Certification: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28e. Date of Injury (Month, Dey Ye		M 1	Yes 2 No		now Injury occur			
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edical	29a. Certifier (Check only one) 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the causa(s) end manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the causa(s) and manner stated.									
Ž	29b. Signature and title of certifier	0		29c. Licen	ise number		29d. Dete signe	d (Month, i	Day, Year)	
	30. Name and address of person who con	appleted cause of death	(Item 23a) (Type.		27837		June			
	LOUIS J. LARCA	7600 (PARROLL	AUEN	UE TAI	ROMA	PARK	m	RYLAND	
ate	31. Date filed (Month, Dey, Year)		Signature	1					7-1-0	
strar	JUN 21 1999	pener	~ D.	Spark	2/					

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 99 21519

									Death							
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sician	_	PHILIF	DERMER								JUNE	22	ay 1		7:20	P. M
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edical Certification: To Be Completed by Physician/Medical Examiner	lind of the state	23a. Part1. Enter the shock, or has disease or condition resulting in death) Sequentialty list confirmed in the shock, or has disease or condition resulting in death) Sequentialty list confirmed in the shock, or has disease or condition resulting in death) Sequentialty list confirmed in the shock of	naral Sarvice Lic	mplications tily one cause a. A	Dua to Dua to Dua to Dua to death but not late of Injury Month, Day Yea.	eath. Do not of the control of the c	22. Nama EDWAR 1091 enter the minus sequence of sequence of sequence of a underlying tient 3 la of y M street, lactor invastigation and sequence of sequence of the sequence o	and Addr. RD SA(ROCK) oda of dyi (i): (i	ass of Facility VILLE ing, such as Onar 26. Plac when in Part 26. Plac ther: 4 N ary at bir/a, data ar opinion, data se number	I. I. I. I. I. I. I. I. I. I. I. I. I. I	23b. Di 24a. W pe 10 28d. Describ	d tobacc Yee as an autoromed? Yas yone) asidance howing (Street is fown, State as cause e, data au 29d. D	CO USE CO	ntribute to 3 Prot 24b. Wa average of a control of the control of	AND Approximately Interval Onset a the cau beby are autopailable primpletion death? I Route I ated. the cau	mate Between nd Death ee of death sy linding of cause 2 No vumber, se(s)
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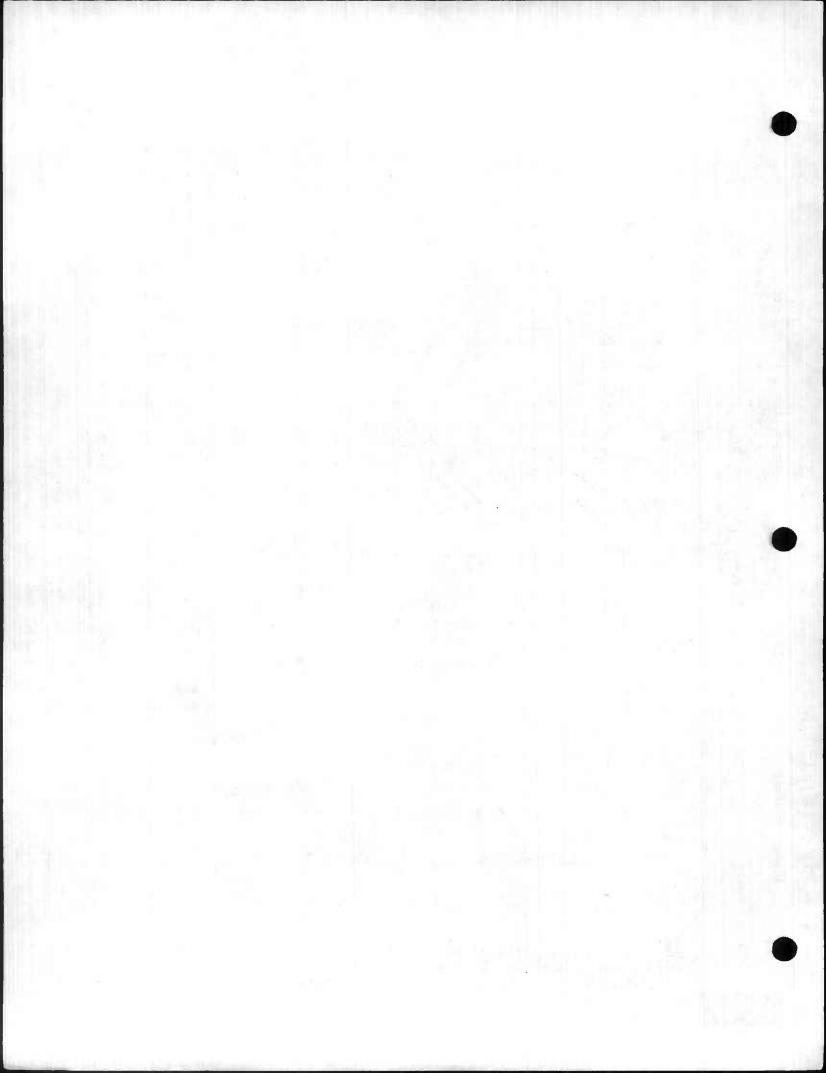


State of Maryland / Department of Health and Mental Hygiene

			•	Cer	tificate of	Death	F	leg. No.	6	1320
	Dhamisis	1. Decedent's Name (First, Middle	, Last)				2. Date of Dea Month	th Day	Year	3. Time of Death
	Physician /Medical	A - A T	ias							4:10 pm
	Examiner					4b. City, Town,	or Location of Death	4c. County of	of Death	
		Suburban Hospi 5. Social Security Number		foot birthdout	If Under 1 Yea	Bethes	da	Montgo	mery	1 (Ci-t 5i
	Funeral Director	578-80-9355	6. Sex 7. Age (In yrs	Yrs.	Months Days		Hrs. 8. Date of Birth (Month, Day Jun 23)	Year)	Coun	
		Usual Residence of Decedent	A 09				Jun 23,	1929	Port	ugaı
	show show	10a. State 10b. County	10c. C	ity, Town or Loc	cation			-	1	0d. Inside City Limits
5	28a-f show	Maryland Montg	omery Ro	ckville	2					1 ☐ Yes 2 ☑ No
4	or 28a-f	10e. Street and Number			10f. Zip Code			l0g. Citizen of W	/hat Coun	iry?
	238				20850	ję		USA		
	r hems 234	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J,S. 13. W	Ves Decedent of Yes, specify Cu	Hispanic Origin' ban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)		k, White,	an Indien, etc.
20	by B		ed 1 Tyes 2 No If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		Specify:	Whi	te
21215-0020	natural, or tem 23s or free by Funeral Dir	15. Decedent	's Education	16a. Deced	ent's Usuel Occi	upation		16b. Kind of But	sinass/inc	dustry
215		(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4or 5+)	(Give I	kind of work done OO NOT use retir	e during most of red)	working			
21	Hygiene. ther then int, the	4	00.0000 (1.40.01)	Masc	n			Constru	ctio	n
pu	1 8 9	17. Father's Name (First, Middle,	Last)			18. Mother's	Neme (First, Middle,	Maiden Sumeme	e)	
Maryland	Mental Me					Emili	a De Jesus	Aguiar		
Mai	th and Mer T is marke traumatic	19a. Informant's Name/Relations					r Rural Route Numbe			Code)
	Health bm 27 ther tr	Maria Dias / 1	Vife 20b	716 P	Seall Av	enue, R	ockville,	MD 20850 20c. Location - 6		wri State
Baltimore,	ent of the state o	1 Burial 2 □ Cremation			sition (Name of setory or other pi cemetery		June 26,19990			
車。	6 2 3	4 Donation 5 Other (S) 21. Signature of Euneral Service								
B	Depart Importu	Statt 2	Smith	50 50	ncis J. O Unive	Colling rsity B	s Funeral lvd. W, Si	Home, In lver Sp	nc. ring	, MD 20901
		23a. Part1. Enter the disease, or shock, or heart failure. List	periodications that caused the dea only one cause on each line.	th. Do not ente	or the mode of dy	ying, such es car	rdiac or respiratory are	rest,		Approximete Interval Between
	hysician	Immediate Cause (Finel	0	-	100. /					Onset end Death
	xaminer	disease or condition resulting in death)	· ANUX	ic B	KHIN	1270	ny			3 DAYS
	i i		_ VISCER	or as e consequ	•	20.44			1	3 442-45
9	ophysician and set to burial-transit	Sequentially tist conditions.	0.	or es e consequ		V (1 47				, 00000
0,	urian a		· ARTENIO	sclera	Tic C	occ/usi	ve Dise	ALA		104em1
68760,	physicis s the bu	that initiated events resulting in death) Last	Due to (or as e consequ	ience of):					
	ding		a DIABe	162	Mel	SNI				loyems
Вох	signed by the ettendir d be detached for use								- 1	,
		Part II. Other significant condition	ns contributing to death but not re-	sulting in the un	derlying cause g	riven in Pert I.	7.5			the cause of death?
	d bed by							98 2 NO	3 P101	bably 4 Unknown
Records, P.O	been sig should b						24a. Was o	an eutopsy	24b. W	ere autopsy findings eilable prior to
900	28 2						- perior	meo:	00	mpletion of cause death?
	page 2 should						1 🗆 Y	es 2 No	10	☐Yes 2☐ No
	octor, p					28. Place of	Deeth (Check only o	ne)		
of VIta	nis ce I dire			ER/Outpatient	3□ DOA O	ther: 4 Nursi	ng Home 5 🗆 Resid	ence 6 □Othe	er (Specif	y)
U d	uner ti	27. Manner of Death 1 ☑ Naturat 5 ☐ Pendin	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		ury at ork?	28d. Describe h	ow injury occurre	ed	
Vision	the the	2 Accident investig 3 Suicide 6 Could r	of he			Yes 2 No	004 1 parties /6	Manual and Alicenter		I Doute Number
7	rs after death. I Director: After to the funeral contribution.	4 ☐ Homicide determi	ned 28e. Place of Injury - At h building, etc. (Speci	ify)	et, tectory, office	9	City or Tow	n, Stele)	er or Hure	al Route Number,
-	Fillie C	29a. Certifier 197 Certifying	Physician: To the best of my kno	owledge, death	occurred at the	time, date end n	lace, end due to the o	ause(s) and mar	nner as s	taled
To the Hoenftel	within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	(Check only 2 Medical I	marniner: On the basis of examination and manner stated.	ation and/or inve	estigation, in my	opinion, death o	occurred at the time, o	late and place, a	and due to	the cause(s)
To the	Withir Comp	29b. Signature and title of certifier	0.0		29c. Licer	nse number		29d. Dete signed	(Month,	Dey, Year)
	Q	CHron	in plums	-	13	806	4	JUNE 1	9	1999
	0	30. Name and address of person	who completed cause of death (Ite	m 23a) (Type, F	Print)	0 1	1 1	. 0	11	44.0
		JAMES	W ? HIBN D	FR	11119	MCKVI	le VK The	4 1600	KVIII	E MY
	State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	1					7003 6
	Registrar	JUN 22 19	99 pera	Ø.	sporks	/				

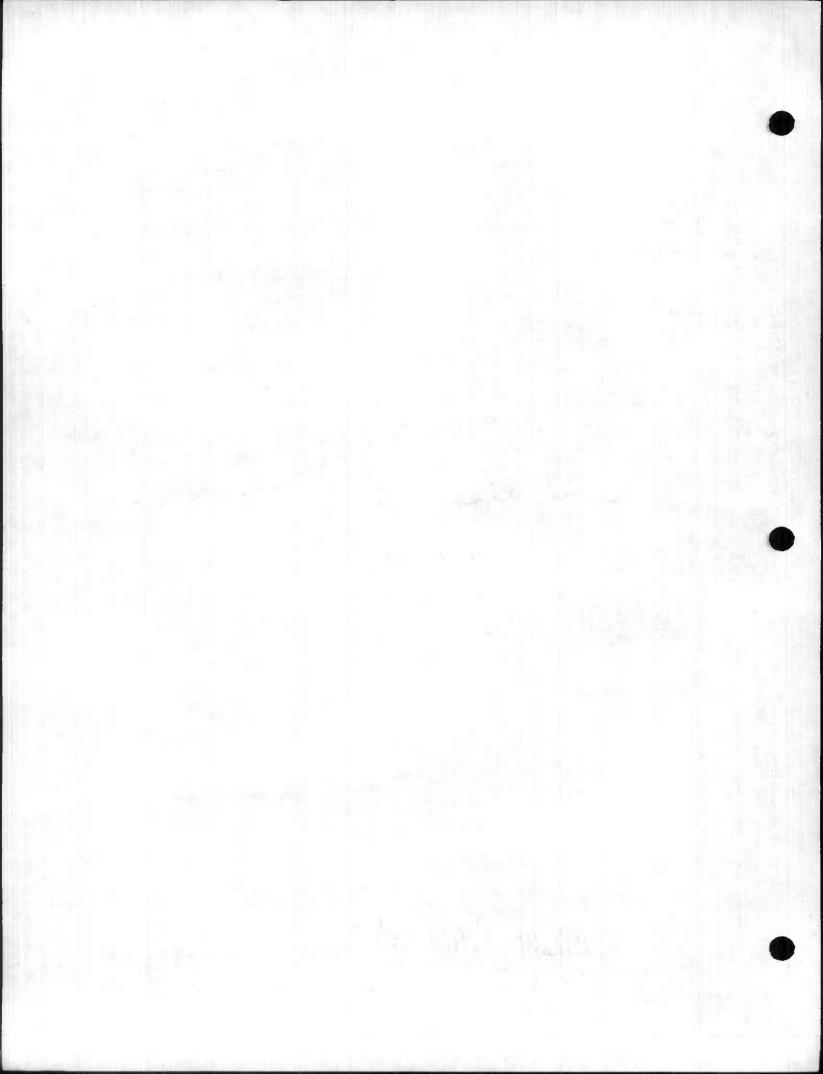
ORIGINAL

0/19/99 1610



State of Maryland / Department of Health and Mental Hygiene

					Cert	ificate of	Death		Reg. No.	9	21521
		1. Decedent's Nama (First, Middle, La	st)					2. Date of De Month	ath Day	Year	3. Tima of Death
Physic /Med			Leonor			Diaz			23, 199		1:20 PM
Exam		4e Facility Neme (If not institution, giv	e street end number)				4b. City, Town, or L	ocation of Death	4c. Count	y of Death	
		9104 Bannister La	ane				Gaithers	nirg	Mont	gome	ry
Funera	1	5. Sociel Security Number 6. S	ex 7. Age	(In yrs. last bir	rthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th Vand	9. Birth	place (State or Foreign
Directo		110-09-5988	□ M 201 F	90	Yrs.	Months Days	Hours Min.	July 15	1908		ombia
D		Usual Residence of Decedent									
how		10a. Stete 10b. County		10c. City, Tow	n or Loca	ation					10d. Inside City Limits
Ma a	Ş	Maryland Montgom	ery	Gait	hers	burg					1 ☐ Yes 2 No
7 TS	5	10a. Street and Number				101. Zip Code			10g. Citizen of	What Cou	intry?
h wit	=	9104 Bannister La	ane			2087	9		Unite	d Sta	tes
deat	Funeral Director	11. Merital Stetus	12. Wes Decedent Ev	ver in U,S.	13. W	es Decedent of	Hispanic Origin? (Sp	ecify Yes or No			ican Indian,
after Market		1 Never Married 2 Merried	Armed Forces?				pan, Mexican, Puerto	Hican, etc.)		ock, White,	, etc.
urs urs	by	3 ☐Widowed 4 ☐ Divorced	If Yes, Give Yeer or Detes:		11	X Yes 2□ No	Specify: Colo	mbian	Specia	Whi	te
d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. It and Mental Hyglene 1.7 is marked other than "natural", or items 23s or 28s-f ahow traumatic event, the Medical Emeriper must be notified as	Completed by	15. Decedent's Ed		16a.	. Decede	nt's Usuel Occu	pation	2	16b. Kind of B	susiness/Ir	ndustry
hin 7	pie	(Specify only highest gra	de completed) College (1-4or 5+	,	lifa. Do	nd of work done O NOT use retire	during most of work	ing			
filed within Hyglene. wher than	E	Clothornary/Occordary (0-12)	4	,	gist	ered Nu	rse		Hospit	tal	
office of the	Be	17. Father's Neme (First, Middle, Last)					18. Mother's Nam	a (First, Middle,	Meiden Sumei	me)	
lid by	ToB	Antonio Rico					Soledad	Rico			
should be nd Mental marked o		19e. Informent's Neme/Reletionship (Type, Print)	196	o. Mailing	Address (Stree	t and Number or Rui		er, City or Town	, Stata, Zi	p Code)
		Leonor L. Sly	(daughter			e as 10					
Hear		20a. Method of Disposition	(444-8114-1	20b. Place o	f Disposi	ition (Name of		Dete	20c. Location	- City or T	own, Stata
Demit. Pages 1 ar Department of Hea mportant: if item 2 any Injury or other pages.		1 Buriel 2 Cremetion 3 4 Donetion 5 Other (Specific				etory or other ple		-24-99	Po 1 + 011	1110	Maryland
it. P	6	21. Signature of Funerel Service Licer		Cilesa		e Crema	-	24))	Dellsv.	TTTE,	Halyland
Departi Importa any Inje		len X	. Kan	SO	Ra	pp Fune:	ral Servic Avenue, Si	es, P.	A. oring, l	MD 20	910
_		23a. Part1. Enter the disease, or com-	olicetions thet caused t	ha deeth. Do							Approximete
Physician		shock, or haart failure. List only	one ceuse on eech line).							Intervel Between Onset end Deeth
/Medical		Immediate Ceuse (Finel	Motost	and a Ca	. 1	C				1	6
Examiner		disease or condition resulting in deeth)	a	Carlotte and St		Cancer				1	6 months
	6		U	oua to (or as a	consequ	ence otj:				1	
Den	edicai Examiner		b	ua to (or as a						1	
rificate be exacuted ng physician and as the bunal-transit	Exa	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying	b	os to (or as a	consequ	erice or).				1	
ficate be ex physician is the burial	Cal	Cause (Disease or injury that initieted events	C	ue to (or es a							
ficate pphy s the	b	resulting in death) Last	D	ue to (or es a c	conseque	ence or):					
certi oding	\$		d								
ath ce attendi	Physician/							1			
the d	ysi	Pert II. Other significant conditions of	ontributing to death but	not resulting ii	n the unc	derlying causa g	ven in Part I.				to the cause of death
that ded deta								יוי	Yes 20 No	3 Pro	obably 4 Unknow
law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	d by							24a Wee	en autopsy	24b. V	Vere autopsy findings
red	ete								emed?	ar Cr	veilable prior to ompletion of cause
has t	du									O	f death?
E ag	Completed							10	Yes 2X No	1	☐ Yes 2☒ No
Physician: The this certificate ral director, pag	Be	25. Was case raferred to medical exeminer?					26. Place of Dea	h (Check only o	one)		
Physic this or	2	1 ☐ Yes 2 ☑ No	Hospitel: 1 ☐ Inpatien	t 2□ER/Ou	utpatient	3 DOA	ther: 4 Nursing He	me 5 N Resi	dence 6 □Ot	her (Spec	ity)
al or Attending Phy s after death. I Director: After this d in by the funeral o		27. Manner of Death 1 ØNeturel 5 ☐ Pending	28a. Deta of Injury (Month, Day		Tima of Injury	28c. Inju	ork?	28d. Describe	how injury occu	irred	
Attending or death, actor: After by the fune	atic	2 Accidant Investigation					Yes 2□No				
Att de cho	SE I	3 Suicide 6 Could not be datarmined	28a. Place of Injur building, etc.	y - At home, fe	erm, stree	et, fectory, office		28f. Location (ber or Ru	ral Route Number,
a after a direction	Certification:		ounding, ord.	(Opouly)							
To the Hospital or within 24 hours afte To the Funerel Dir completely filled in		29e. Certifier 1 Certifying Ph	ysician: To the best of	my knowledge	e, death o	occurred at the t	ima, data and place,	and dua to tha	cause(s) and m	nanner as	stated.
n 24	edical	one) 2 Medical Exam	end menner stete		NOT INVA	stigation, in my	opinion, death occur	red at the time,	uata and place	, and dua	to the cause(s)
Withi To the	Ž	29b. Signeture end title of certified	1111	1/1.1	111	29c. Licen	se number		29d. Date sign	ed (Month	, Day, Year)
7		N/W W/K	M PU	IVVI	VVV) 7	38589		Tana O	, 10	00
		30. Nema and address of person who	completed cause of de-	ath (Item 23e)	(Tyne P	_	20702		June 24	+, 19	77
							Doc 1	#207 P	ockwill	o M	20852
	ate	Jonathan S. Plot 31. Date filed (Month, Dey, Year)	32. Regiftrar	's Signature	10 01			"2019 N	OCKVIII	الالا وعا	20032
Regis		JUN 2 5 1		was	1.	Span	K				
			7		0	- B					



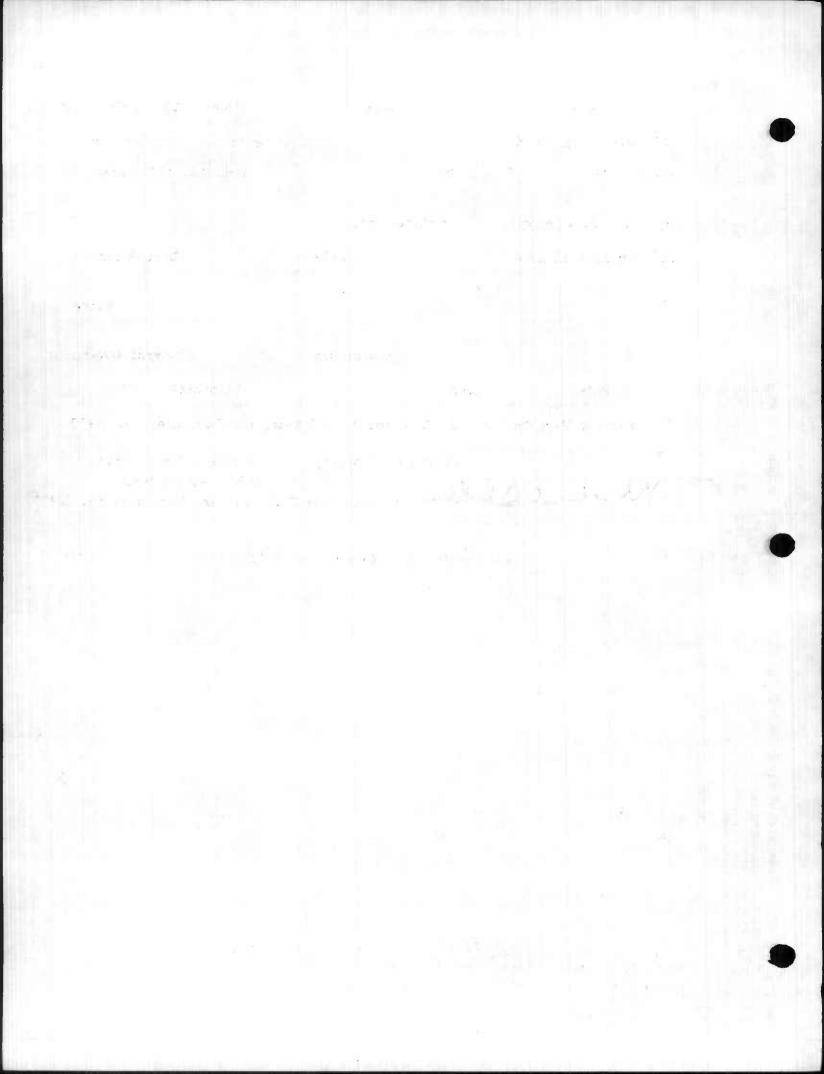
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedant's Nama (First Middle Last) 2 Data of Death 3 Time of Death **Physician** Dincau 1999 5:00 AM June 20, Marv /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 224 Summit Hall Road Montgomery Gaithersburg if Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number If Under 1 Year 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days 1 M 2 X F Months Yrs. 89 24, 1909 Ohio Director Oct. 296-07-7207 Usual Rasidance of Dacedant the Marylend 10a State 10b County 10c. City. Town or Location 10d. insida City Limits 7 is marked other than "naturel", or thems 23s or 28s-f shot traumatic avent, the Modical Examiner must be morfed at 1 X Yas 2 □ No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? with 224 Summit Hall Road 20877 United States Funeral death 12. Was Decedent Evar In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Bace - American Indian Black, Whita, atc. permit. Pages 1 end 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. I have 21's merked other than "naturel", or fleneny Injury or other traumatic avant 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ 3₺ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Elementery/Secondary (0-12) College (1-4or 5+) 8 Researcher Federal Government 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Peter CiCi Leone Elizabeth 19e. Informent's Neme/Ralationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Joan Dincau/ Daughter in Law 224 Summit Hall Road, Gaithersburg, MD. 20877 20a. Mathod of Disposition 20b. Plece of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stata Data 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramovai from Stata 4 ☐ Donetion 5 ☐ Other (Specify) 6/24/99 Cadiz, Ohio Greenwood Cemetery 22. Nama and Addrass of Facility DeVol Funeral Home Signatura of Funaral Service Licansaa 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intarval Batween Onsat end Deeth **Physician** Immediata Causa (Finel disease or condition resulting in daeth) /Medical · CLREBRAL VASCULAR ACCIDENT Examiner Examiner atherosclerosis physicien end the burial-transit Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Diseasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequence of): 68 USB (Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown ð 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? complation of cause of death? 1 ☐ Yas 2 No 1 ☐ Yas 2 No certificate or Attending Physician: 25. Was casa referred to medical exeminer? Be 26. Plece of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 1 Yes 2 No 10 this funeral 28a. Data of Injury (Month, Day Yaar) 27. Mennar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: After Naturai 5 Pending after death. 1 Yas 2 No Invastigation 2 Accident 6 Could not be datarmined 3 Suicida 28a. Pleca of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 24 hours a Hospital 29a. Cartifier 🔀 Certifying Physician: To tha best of my knowladga, daath occurred at tha time, deta and place, and due to the causa(s) and mannar as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the causa(s) and manner stated. within 2 the 29c. Licansa number 29d. Data signad (Month, Day, Year) 29b. Signature and title of certifia: 0 D14555 MD 30. Name and addrass of person who completed cause of death (Item 23e) (Type, Print) 19241 MONT gomery Village Ave, Mont. Village MD Winchell

State Registrar

31. Dete filed (Month, Day, Year)
JUN 2 2 1999

32. Registrar's Signatura

Sereva

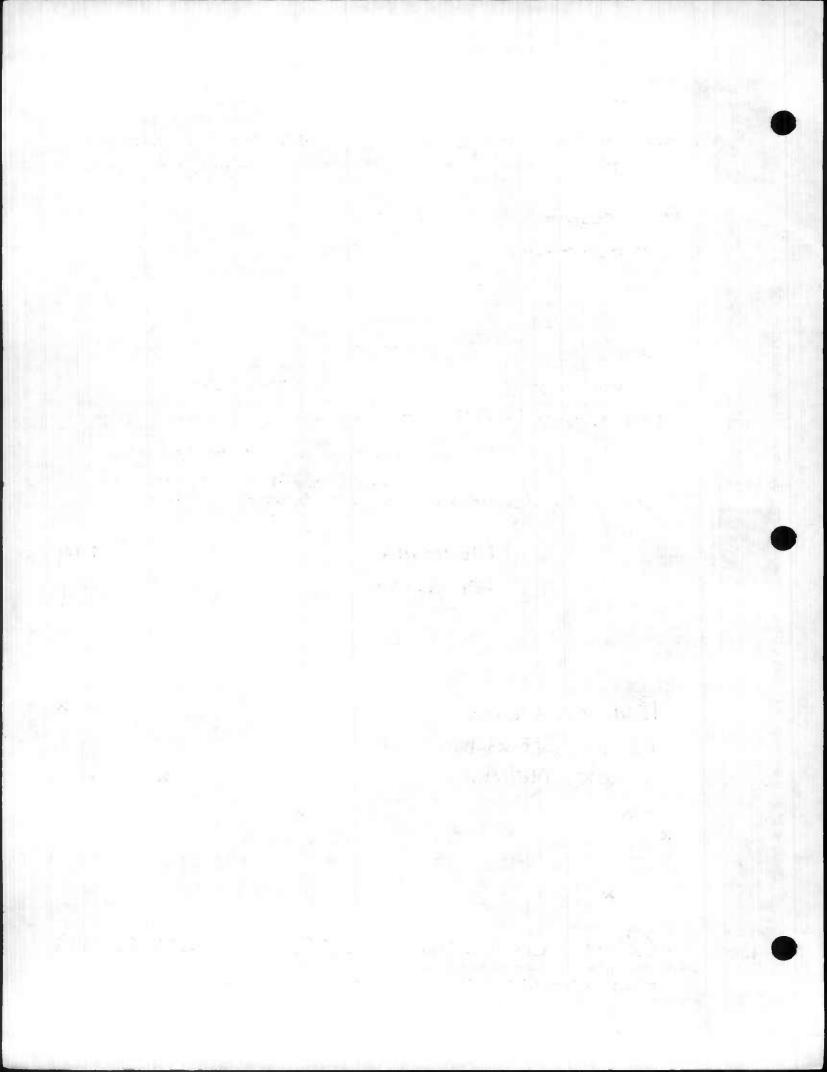


State of Maryland / Department of Health and Mental Hygiene 99 21523

			Certificate of	f Death	Reg	3. No.					
	1. Decedent's Name (First, Middle, La	st)			2. Date of Death	Day Ves	3. Time of Death				
Physician	TIMOTHY	P. DUVALL			June 2	Dey 1999	8:am				
/Medical Examiner	4a Facility Neme (If not institution, give	e street and number)		4b. City, Town, or Lo		4c. County of Death					
	Montgomery Villa	ge Care and Re	hab.	Gaithersh	ura	Montgome	erv				
Funeral Director	5. Social Security Number 6. S			r If Under 24 Hrs. s Hours Min.	8. Dete of Birth (Month, Day,) July 12,	(ear) 9. Birth	place (State or Foreign intry) Land				
	Usual Residence of Decedent				oury ro,		7 2010				
Maryland f ahow	10a. State 10b. County Md Montgome		ty, Town or Location Gaithersburg				10d. fnside City Limits ¥ Yes 2 □ No				
1284 the	10e. Street and Number	-1	10f. Zip Code		100	g. Citizen of Whet Cou	intry?				
O offer death with the Mar of thems 23s or 28s-f a other must be notified funeral Director	8615 Emory Gro	ve Rd,	2087	7		U.S.A.					
0 0	11. Maritel Status 11. Nevar Married 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2X No If Yas, Give Year or Dates:	I.S. 13. Wes Decedent of If Yes, specify Co	Hispanic Origin? (Speban, Mexican, Puerto o Specify:	cify Yes or No- Rican, etc.)	14. Race - Amar Bleck, White					
5-C	15. Decedent's E		16a. Decedent's Usuat Occ	upation e during most of worki	na 16	6b. Kind of Businass/li	ndustry				
T = 14 5	Elementery/Secondary (0-12) Never	College (1-4or 5+)	Disabled	e during most of working)		None					
D PER O	17. Father's Neme (First, Middle, Last)		18. Mothar's Nama	(First, Middle, Ma						
yland 212 build be filed with Mental Hyglena. arked other ther atic event, the	Frank M.	Duvall		Ida	Sellman	1					
Maryland d 2 should be flie d 2 should be flie th and Mentel Hy 7 is marked othe treumatic event To Be C	19a. Informant's Name/Reletionship (19b. Meiling Address (Stre				ip Code)				
Magning 2. 16 or tree.	William T. Duva	(Rmthar)	8615 Emory (
Baltimore, Maryland 3 pemit. Peges 1 and 2 should be filed Department of Heelth and Aentel Hygi Important; if Item 27 is marked other eny injury or other treumatic event, page. To Be C	20a. Method of Disposition 1 Surial 2 Cremetion 3 4 Donation 5 Other (Special	Removel from State	Place of Disposition (Name of cometery, crematory or other p pary Grove Church			oc. Location - City or T					
Parent P	21. Signature of Funeral Service Limit		-				9, 2.00				
Depa Impo	YMORK	Promoteur		Funeral Ho shington S							
	23a. Part1. Enter the disease, or corr shock, or heart failure. List only	plications that caused the deal					Approximeta				
Physician	snock, or neart larure. List only	one cause on aach me.					Intarvel Batween Onset and Death				
/Medical	Immediete Causa (Final diseasa or condition	ENFELL	MONSA			1	DAYS				
Examiner	resulting in death)		or as a consequence of):				12				
		1	DAY								
K 68760, antificete be assented ing physicien and as the burletraneit Medical Examiner	Sequentially list conditions, if any, leading to immediate DEHYJUATON Due to (in as a consequence of):										
68760, efficete be and g physicien as the burlai-	Sequentially tist conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events	c. Due to (c	or as a consequence of):			1					
	resulting in death) Last	d									
P.O. BO) at the death of by the ettend stached for us.	D 48 00 1 10 10 10 10				1 001 0141-1	1					
hat the deet of by the ette detached for Physicia	Part II. Other significant conditions of		sulting in the underlying cause :	given in Pert I.			to the cause of death?				
	TERNICIOUS				1 1 701	2 NO 3 P	obably 4X Unknow				
require peen should	MENTAL R	Etaredation			24a. Wes an performe	ed?	Vera eutopsy findings vailable prior to ompletion of cause of deeth?				
I Rec The lew ate has b paga 2 s	Dibbetes	MEllitus			1 ☐ Yes		☐ Yas 2☐ No				
ordificate irector, page 0 Be Co	25. Wes case rafarred to medicat axaminer?			26. Place of Death	(Check only ona,)					
Of VIta Physicien: this cartific ral director, TO Be (1 ☐ Yes 2√2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ DOA	Other: 4 Nursing Ho	me 5 Rasiden	ce 6 Othar (Spec	eity)				
iding Physith. After this funeral diametric funeral diametric funeral diametric funeral diametric funeral diametric funeral diametric funeral diametric funeral diametric funeral diametric funeral diametric funeral diametric funeral diametric funeral diametric funeral diametric funeral diametric function func	27. Manner of Death 1 Neturat 5 Pending 2 Accident investigation	28a. Data of Injury (Month, Day Year)	28b. Time of Injury M 1		28d. Describe how						
DIVISION of the control of the contr	3 Suicide 6 Could not b	9 One Plans of Lairns At h	9	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Routa Number,					
Division of Vital Re To the Hospital or Attending Physicien: The in within 24 hours after desth. To the Funeral Director: After this cardificate he completely filled in by the funeral director, page Medical Certification: To Be Com		ysician: To the best of my knowniner: On the basis of axamina									
Mec Mec	29b. Signature and fittle of certifier	and manner stated.	29c tine	nse number	29	d. Data signed (Month	. Dav. Year)				
F3F8	Dalie I A	Rough	7	2/97		SUNE 21,	1999				
	James A	Denne W	D 30	1676	_	JUNE ZI	1111				
	30. Name and address of person who			na n= 1 -	11						
	Dr Gabriel Ber 31. Date filed (Month, Day, Year)			Ka, Rockvi	IIe, Md						
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signa									

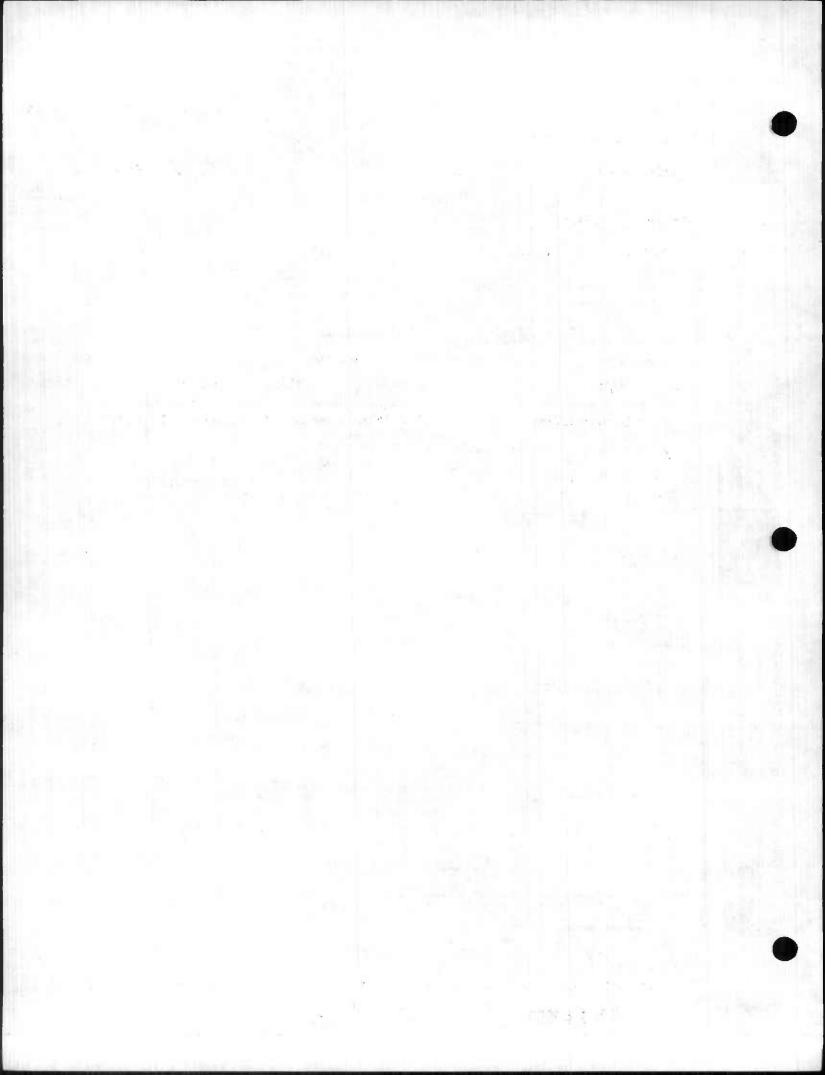
DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Otate of	iviai yiai		rtificate of	Death	-	Reg. No.	2	1524
П	Physicia	an	1. Decedent's Neme	(First, Middle, L.	nst)					2. Date of De Month	Dey	Year	3. Tima of Deeth
Ę.	/Medic	al	Elsie Vi							JUNE	22	1999	6:15 am
	Examin	er	4e Facility Name (#			per)			4b. City, Town, or L				
			Sacred H					Milledge 4 Vees	Cumberl			llega	-
	Funeral Director		5. Social Security Nu 219–34–6	405	Sex 1□ M 2 F 7.	Age (in yrs. 92	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir Month, De Aug. 2,	1906	9. Birthpl Count Penns	ece (Stete or Foreign ly) ylvania
	the Maryland 28a-f show solified at		Usuel Residence of I	10b. County			y, Town or Lo					10	Od. Inside City Limits
	o Maria	Directo	Maryland	Allegar	ıy		Frostb						1√ Yes 2□No
	1 6 M	듬	10e. Street and Num			. 23.5		10f. Zip Code	1500		10g. Citizen of V		try?
	4 23 mat	ara l		ysuckie	Lane, Ap				1532			JSA	
020	72 hours after death with the Maryla netural', or items 23a or 28e-f shor dical Examiner must be notified at	by Funeral	11. Meritel Status 1 ☐ Never Merrie 3 ☑ Widowed 4		12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Dete	es? ☑ No		wes Decedent of F If Yes, specify Cuba 1 ☐ Yes 2X No	tispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Blac	e - America k, White, o	etc.
ĕ	2 hou			15. Decedent's E			16a. Deced	dent's Usuel Occup	pation		16b. Kind of Bu	usiness/Ind	ustry
21215-0020	Pin 7	Completed	(Special Elementery/Second	y only highest gr	ade completed) College (1-4	or 5+)	(Give	kind of work done DO NOT use retire	during most of work	ing			
	N S S S S S S S S S S S S S S S S S S S	Cor	88				<u> </u>	Home	maker			Own	Home
E D	3 T 8 F	Be	17. Father's Neme (F)				18. Mother's Nem			(0)	
yla	Menta Menta erked wite e	10	James Bo	•					Lillie				
Maryland	1 and 1 and		19a. Informent's Ner						and Number or Rur				Code)
	Teat Teat The Z	-	James E. 20a. Method of Dispo	·	on	20h F		sition (Neme of	eet, N.,	Dete	20c. Location -		um State
Baltimore	Pages nert of mrt: m la mry or o		No Burial 2	Cremetion 3 [Removel from Sto	ete C	emetery, cres	netory or other ple					
Ē	orthon or the orthon	1	21. Signature of Fun	Other (Speci		For	t Hill	Cemetery Name end Addre	June 26,				
Ba	Dep in particular in particula		De L	u De	man				Ne		neral Ho 5, Grant		P.A. le, MD 2153
	Physician		23a. Part1. Enter the shock, or heart	e diseese, ér con feilure. List only	plications that cau one cause on eec	sed the deet h line.	h. Do not ent	er the mode of dyir	ng, such es cardiac	or respiretory a	rrest,	1	Approximate Intervel Between Onset and Death
	/Medical Examiner		Immediete Cause (F disease or condition resulting in death)	inal	0.	SEPTI	C SIX	ven				TWO SO	
		5	rosuling in doding				or as a consec					1	T and Grand
	per user	edical Examiner			b		lyspic	2000	grelson	ne		1	wogen
,	ficate be executed physician and as the burial-transit	Exa	Sequentially list con- if any, leading to im- cause. Enter Underl Cause (Disease or in	ditions, nediate		Due to (o	r as a conseq	(uence of):	U				
68760,	ysicia a bur	Ca	that mitieted events		C	Due to (o	r es e conseq	uence of):					
			resulting in death) La	ast		000.00							
Box	th cer endir r usa	2			d								
O.	the att	sici	Part II. Other signific	ant conditions	contributing to deat	h but not res	ulting in the u	nderlying cause giv	ven in Part t.	23b. Did	tobacco usa co	ntributa to	the cause of death?
P.O.	as that the death certificate by the attending be detached for use a	Physician/M	Covan	an and	m she	ence	CIT	needro	to bear to	10	Yan 2000	3 Prob	eably 4 Unknown
ds,	and be	ğ			1			3	"	-000		045 144	an autonou fin dia an
Records,	The law requires that the death certifies has been signed by the attending page 2 should be detached for use a	Completed by	Drobel	i me	llulus C	hvore	c 8 38 h	riche Le	under for	24a. Wes	an autopsy ormed?	ava	ore eutopsy findings hilable prior to inpletion of cause deeth?
	The lands	EO	They	Kran	Soche					10	Yes 2 DiNo		Yes 2□ No
ta	an: rtifica stor, p	8	25. Wes case referre	d to medical					26. Place of Deet	h (Check only	one)		
>	yelo dire	9	examiner? 1 ☐ Yes 2 ☐ N	lo	Hospitel: 1 10np	atient 2	ER/Outpatier	t 3 DOA Oth	er: 4 Nursing Ho	ome 5 Resi	dence 6 Oth	er (Specify)
Division of Vital	Ing Ph After th funeral		27. Manner of Death Natural	5 Pending		njury Dey Year)	28b. Time of Injury	Wor	yat rk? Yes 2 □ No	28d. Describe	how injury occur	red	
8	Attanding ir death. ector: Aftai by the fune	Ca	2 ☐ Accident 3 ☐ Suicide	investigation	e one Diese of	Injury - At he	ome farm str	eet, fectory, office	105 20110	28f. Location /	Street and Numb	er or Rura	l Route Number.
Š	or A	To l	4 Homicide	determined	building	etc. (Specif	y)	out, rootory, omoo		City or To			
	To the Nospital or Attanding Physician: Tha law within 24 hours aftar death. To the Funeral Director: Aftar this certificata has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only 2	Certifying Pl	niner: On the basis	s of examine	wledge, death	occurred et the tir	me, date and place, ppinion, deeth occur	end due to the red at the time,	cause(s) and me date end piece,	enner as st and due to	ated. the cause(s)
	of the of the omple		29b. Signature and ti	tle of certifier	and manner	steted.		29c. Licens	se number		29d. Date signe	d (Month, i	Dey, Year)
	- S - 0			Hadle				1 2	6907		THATE 4	9	1000
	2	-	30. Name and addres	//	completed cause of	of death (Item	23a) (Tyne		- 1		JUNE 2	1,	1333
	K		Hargit Si						herland	וני מא	502 #	D-269	907
	Stat	е	31. Date filed (Month	, Day, Year)	32. Reg	istrar's Signe	ture			riv ZI	JUZ		
	Registra	ır	J	UN 241	999	energy	A	Long	61 1				



Physician /Medical Examiner ilcian and burial-transit The law requires that the death certificate be executed physician s the burial Box 68760. 95 65 080 P.O.

Records.

Division of Vital Attanding Physician:

8

Hospital

filled in

completely

within 2 2

edicai

29a. Certifier

(Check only

29b. Signature and title of certifi-

one)

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

Be

Funeral

Director

mass or death with

Rema 2

"natural", or Itam

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
art: If item 27 is marked other than 'natural', or ite ury or other transmit award, the Medical Eastmin ury or other transmets award, the Medical Eastmin.

permit. Pages Department of Important: If It any Injury or o

the Manyland or 28a-f show

21215-0020

Baltimore, Maryland

Examiner Physician/Medical signed by t þ should Completed page 2 : certificata funeral director. Be Certification: To this After 24 hours after death.

Funeral Director: A 3

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 25. Was case referred to medice! examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 DNatural 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of fnjury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

State Registrar

31. Dete filed (Month, Day, Year) JUN 23 1999

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

2 D Ma

300 West 9th Street, Frederick, Maryland 21701 Casper E. Cline, M.D. 32. Registrar's Signature

Conflying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

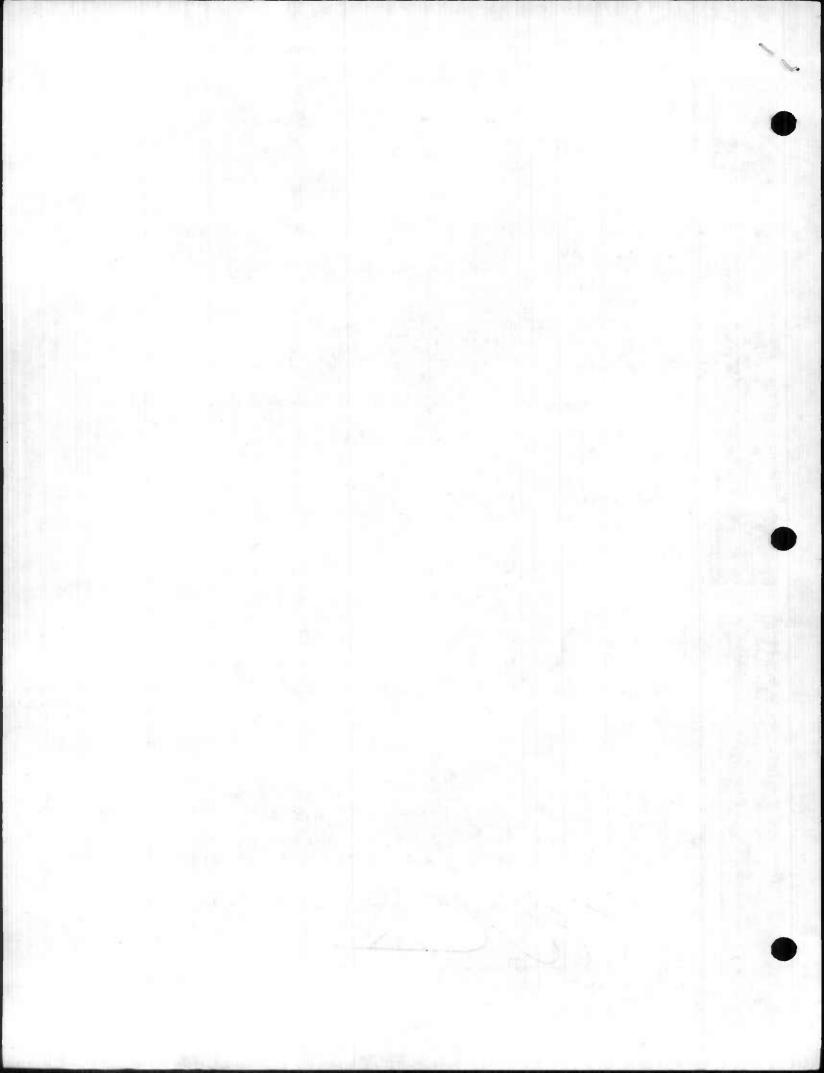
The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner product.

D16428

29c. License number

29d. Dete signed (Month, Dey, Year)

6



State of Maryland / Department of Health and Mental Hygiene

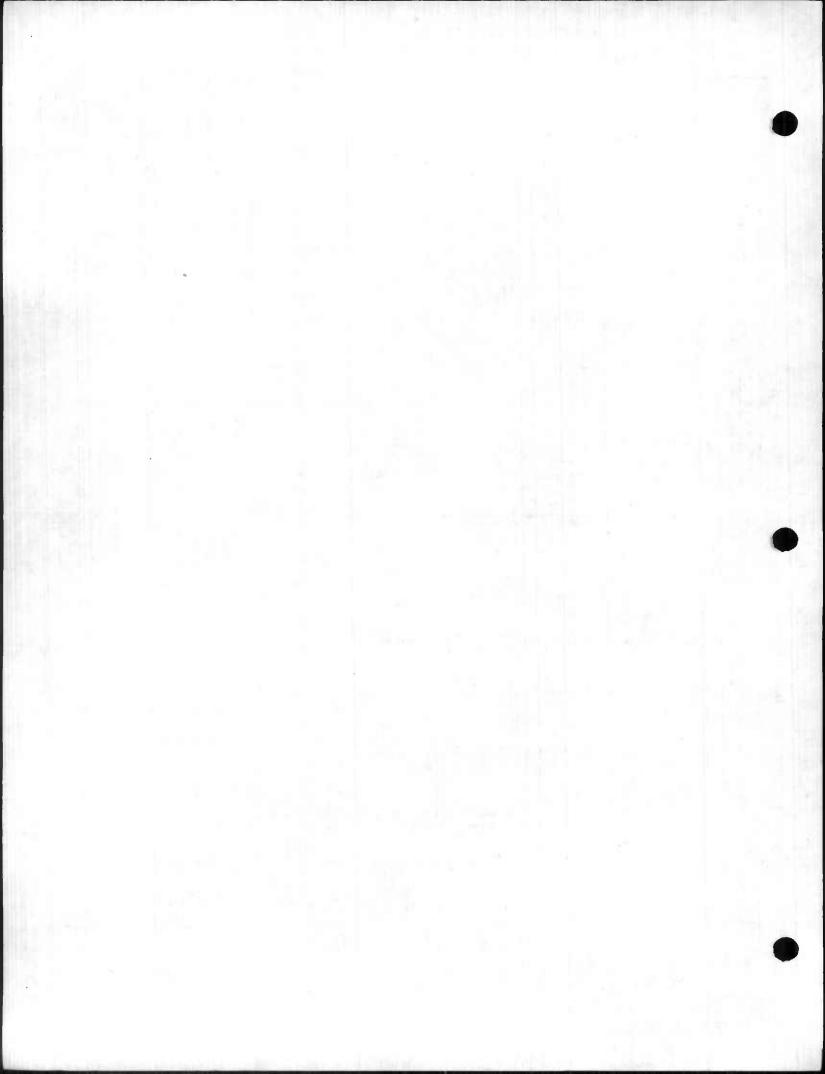
				•	Certificate of L	Death	Reg. No.	21020
	Physic		1. Decedent's Name (First, Middle, Last) CATHERINE	LE	CKERT	2. Data of Month	Death	3. Time of Death
0	/Medi Examii		4a. Facility Nama (If not institution, give street a	and number)	U.T	Sity, Town, or Location of Do	eath 4d County of D	eath
1	Funerai		5. Social Security Number 6. Sex	7. Age (In yrs. last b	oirthday) If Undar 1 Yaar	if Undar 24 Hrs. 8. Data of Hours Min. (Month,	Birth 9.	Birthplace (State or Foraign
	Director		212-01-5142 1 M 3	% 83	Yrs. Months Days	Hours Min. FEB	Day 2001/1916-	MARYLAND
	ahow		10a. State 10b. County	10c. City, Tox	wn or Location	100		10d. Insida City Limits
	r 28a-f ah	recto	MD, MONT GOT	MORY	KOCKUI L	lt	10g. Citizen of What	Yes 2□No
	ath with 23a or	ral Di	9701 - VELRS	S DR.	208	50	US	A
21215-0020	ours efter de ral', or Itama Examine l'	by Funeral Director	1 Navar Married 2 Married 1 Hr	s Decedant Evar in U,S. ned Forces? Yes 2000 es, Give ar or Dates:	13. Was Dacedant of Hi It Yes, specify Cubal 1 ☐ Yes 2 No	spanic Origin? (Specify Yes or n, Mexican, Puerto Rican, atc.) Specify:	No- 14. Raca - A Biack, W Specify:	merican Indian, Thire, etc.
15-0	C * 6	jetec	15. Decedent's Education (Specify only highest grade comp	leted)	a. Decedent's Usuel Occupa (Give kind of work done d life. DO NOT use retired	ition luring most of working	16b. Kind of Busine	ss/Industry
	ed within rgiene.	Completed	Etementary/Secondary (0-12) Col	lege (1-4or 5+)	HOMEM	AKER	AT	HOME
land	ld be fill ental H ked oth	To Be	17. Fathar's Nama (First, Middla, Last)	KERT		18. Mother's Neme (First, Mid	dle, Maiden Sameme)	NERED FIN
Maryland	s 1 end 2 should be filled within if Health end Mental Hygiene. Item 27 is marked other than "rother traumatic event, the Mes.	-	19a Intormant's Name/Relationship (Type, Pril	11) 19	b. Mailing Address (Street e	and Number or Rural Route Nu	mber, City on Town, State	e, Zip Code)
	Health Health tam 27 other to		20a. Method of Disposition	LHAKU 20b. Place	ot Disposition (Name of	VEYRS	20c. Location - City	or Town, State
Baltimore,	Peges ment of I ant: If its ury or of		Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	from State	ery, czemetory prother pla	EM 621/9	9- BALT	IMORE MO
Ball	permit. Peges 1 and 2: Department of Health er important: If Itam 27 is any Injury or other trau		21. Signature of Funeral Service Licensee		22. Name and Addras	s of Facility	1200 1	CT INACO
2			23a. Part1. Enter the disease, or complications shock, or heart tailure. List on yone caus	used the death. Do	not enter the mode of dying	g, such es cerdials or respireton	y errest,	Approximate Approximate
	Physician /Medicai		Immediate Ceuse (Final		` `			intervel Between Onset and Death
	Examiner		disaase or condition resulting in death)	1.000	ronsequence of):	epsis		12 hours
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00	that the death certificete be executed ed by the attending physicien end deteched for use es the bunal-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.	Due to (or as a	consequence of):			
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Box	th certifications that the second of the sec	2	d					
P.O. I	the dea y the at	Physician/	Part II. Other significant conditions contributing	g to death but not resulting	in the underlying ceuse give			uts to the cause of death?
	signed b	by P	Covonary	Mrtery	auxeas	e1	U Yss 2 U No 3 U	Probably # Unknown
Records,	aw requast been 2 should	Completed	A (3 her	nees () is ease	24a. W	/as an autopsy enformed?	b. Were autopsy findings available prior to completion of cause of deeth?
ital		Be Co	25. Was cese reterred to medicel			26. Place of Death (Check on	V one)	1 Yes 2 No
of Vital		ရ	exeminer? 1 Yes 2 No Hospital	1 ☐ Inpatient 2 ☐ ER/O		r: Nursing Home 5 ☐ Re	esidence 6 Other (S	pecify)
ion	Attending F or deeth. ector: After by the funer	ation	27. Manner of Deeth 1 Naturel 5 Pending 2 Accident investigation		Time of Injury Work	at ? 'es 2 □ No	be how injury occurred	
Division	うだった	Certification:	4 Homicide	Place of injury - At home, fabuilding, etc. (Specify)		City or	n (Street and Number or Town, State)	
	To the Hospital within 24 hours of To the Funeral Completely filled	edical	2 Medical Examiner: Un	To the best of my knowledge the basis of examination ar if menner stated.	e, deeth occurred et the time nd/or investigation, in my op	e, date and piece, end due to the time of the time.	ne ceuse(s) and manner ne, dete and place, and c	as stated. fua to tha cause(s)
	To the Tour Comp		29b. Signatura and title of certifier	Mes	29c. Licanse	number	29d. Data signad (Mo	onth, Day, Year)
	5)		30. Name and address of person who, completed	d ceuse of death (Item 23a)	(Type, Print)	55158	Jane 1	0, (7/7
1	3/	1	Daniel Taller	m 128	50 Midd	lebrook Kd,	German.	toun, wo
0	Sta	e	31. Date tited (Month, Day, Year)	22. Registrar's Signature	1	/		

MARCH PROPERTY TOTAL TOTAL STATE OF THE STAT

State of Maryland / Department of Health and Mental Hygiene 99

							Centi	ricate of	Death	1		Reg. No.		
	Physician /Medical	1. Decedent's Nam Siegfri		nst)		Ermanı	n					19, Day 1999	Year	3. Time of Death 6:05 AM
	Examiner	4a Facility Name (Suburt	lf not institution, gi pan Hospi		umber)				4b. City, To Beth		cation of Dea	Mont	gomer	
	Funeral Director	5. Sociel Security N 152-18-3	3397	Sex 1⊠M 2□F	7. Aga 8	(In yrs. last bir 9		Months Days		Min.	8. Data of Bi (Month, D July	rth ay, Year) 27, 1909	9. Birth Cou	place (State or Foreign intry) Germany
	with the Maryland a or 28a-f show be notified at Director	Usual Residence of 10a. Stata MD	10b. County Montgo	mery		10c. City, Tow Roc	kvill	Le						10d. Insida City Limits 1 ☑ Yas 2 ☐ No
B. M.	23e or 3 ust be n al Dir	10e. Street and Nu	mber Jefferso	n St #	217			10f. Zip Code 208	852			10g. Citizen of USA	What Cou	ntry?
020	un atter des af, or lems Examiner m by Funer	11. Marite! Status 1 □ Nevar Marr 3 ☒ Widowed	ied 2 Married	12. Was De Armed F 1 Yas If Yas, G Year or I	orcas? 2[€] No iiva			s Decedent of Fes, specify Cub			ecify Yaa or N Rican, etc.)	Bla	ea - Ameri ck, Whita, v:Whita	
Maryland 21215-0020	ed within 72 ho ygiene. ser than "natur it, the Medical.	(Special Special Speci	15. Decedent's E cify only highest gr andary (0-12)	ade completed) (1-4or 5+)	(Give kin lifa. DO	t's Usual Occup d of work done NOT use retire Vholesa	during mos d)	st of worki	ing	16b. Kind of B		dustry
yland		17. Father's Nama Michael		1)							(First, Middle e (unk	, Maidan Suman		
Mar	DI 中華書	19a. Informant's No.	ame/Relationship nann-Son	(Type, Print)								ing, MD		
imore,	-138		position □ Cremation 3 5 5 □ Othar (Speci		Stata		y, cremat	on (Nama of ory or other pla vid Cem		6	Dete /22/99	N. Laud		
An)	permit. Page Department of Important: If I any Injury or ands.	21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, MD 208 23e. Pertl. Entar tha disaasa, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										352		
605	Physician /Medical Examiner	Immediata Causa (Final diseasa or condition rasulting in daath) List only ona cause on aach lina. Athenosolenotic heavt disease Due to (or as a consequence of):									1	Approximate Interval Batween Onsat and Death Yeary		
6/9/99 Box 68760,	n certificate be executed anding physician and use as the buriel-transit in/Medical Examiner	Sequantially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events rasulting in death)	5	c		ua to (or as e o								
P.O.	es that the death igned by the atten be detached for u by Physiciar	Part II. Other signif	Conticonditions	contributing to a	death but	not rasulting in	tha unde	ortying causa give	ven in Part	I		tobacco usa co	ntributa t	to the cause of death?
ried ecords,	aw requires the second	Aibri	lation	n, and	emi	id					24a. Wa	s an autopsy ormed?	C	Vare autopsy findings vailable prior to ompletion of cause of death?
100 E	certificate ha rector, page	25. Was casa refer	red to medical	1					00 Di-	1 D11		Yes 2 No	1	□ Yas 2 No
5	Physician: this certific ral director, TO Be (axaminar?		Hospital:	Apatien	t 2 ER/Ou	tpatient	3 DOA Oth	hor		n <i>(Check</i> on <i>ly</i> ma 5□ Res	idence 6 Oth	er (Speci	ify)
Cann,	on the Co	27. Mannar of Deat 1 Natural 2 Accident 3 Suicide	5 Pending invastigatio	n aga Diag	nth, Day	Year) 28b. T	ima of njury			No	28d. Dascribe	how injury occur	red	rel Route Number,
man	poplal or Attendi hours after death hours after death hy filled in by the t cal Certificati	4 Homicide	datarmined	build	ling, etc.	(Specify)					City or To	iwn, Stata)		
图	the H bin 24 the Fu nplete	29a. Certifiar (Check only one)	1 Certifying Pr 2 Medical Exam	niner: On the t		xamination and		tigation, in my o	opinion, dea			, date and placa,	and dua	to tha cause(s)
•	5	29b. Signatura and	icia L	Tom	ska	, mo	9	29c. Licens	5/9/	6		June June	19)	1999
	State Registrar	30. Nama and addr Parricia 31. Date filed (Mon	ass of person who I now Str. Day, Year)	ko, MD)	Registrar	ath (Item 23a) (Roc 'a Signatura	Type, Pri	The Pik	(e,#3	48, 1	Rock	ville,	MD	20852

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death 1221 6 4a Fecility Neme (If not institution, giva street and number) (11ASHINGTON ADVENTIST 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY TAKUMA If Under 1 Yeer If Undar 24 Hrs. 8. Data of Birth (Month, Day, Yaar) APRIL 25, 1920 9. Birthpleca (State or Foreign Country) WASHINGTON, D.C 5. Social Security Number 7. Age (In yrs. last birthday) DEM 20 F 579 07 0204 79 Usual Rasidance of Decedant 10d. Insida City Limits 10b. County 10c, City, Town or Location MONTGOMERY 1 Yas 2 No OLNEY 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 3512 KING WILLIAM DRIVE 20832 UNITED STATES 14. Race - Amarican Indien, Black, Whita, atc. 12. Was Decedant Ever in U,S. Armed Forcas? 1 Xas 2 □ No M Yas, Giva Year or Datas: Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 1 Nevar Married 2 Married 1□ Yas 2XNo Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade complated) Elamentary/Sacondery (0-12) Collaga (1-4or 5+) ESTIMATOR - ENGINEER UTILITY 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Neme (First, Middle, Maidan Sumama) ALVA VIOLA SHOOP 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 3512 KING WILLIAM DRIVE, OLNEY, MD. 20832 20b. Place of Disposition (Nama of cematary, cremetory or other place) 20c. Location - City or Town, Stata ALEXANDRIA, VA.

HAROLD E. EARP, SR. 19a. Informant's Name/Ralationship (Type, Print) EDWINA H, EARP, WIFE 20a. Mathod of Disposition 1 ☐ Burial 2 Cramation 3 ☐ Ramoval from Stata METROPOLITAN CREMATORY 6/19/99 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licensaa 22 Name and Address of Earlity
MURIEL HOME
BARBER FUNERAL HOME

muriel N. Barker P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or haer failure. List only one ceuse on each line. Approximate Interval Batween Onsat and Deeth

Immediata Causa (Final disaasa or condition rasulting in daath)

Physician

/Medical

Examiner

10a Stata

Director

Funeral

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Completed

MD.

Funeral

Director

show

7 is marked other than "naturel", or items 23s or 28s-f shov traumatic event, the Medical Examinal must be notified at

permit. Peges 1 end 2 should be filed within 72 hours after Department of Health end Mental Hygiane. Important: If Item 27 is marked other than "naturel", or ite any Injury or other traumatic event, the Medical Examina

Physician

/Medical Examiner

physician end the burial-trans

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To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A

50+

Division of Vital Records, P.O. Box 68760

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

Baltimore, Maryland 21215-0020

with the Maryland

death

Sequantially list conditions, if any, laading to Immadiata causa. Entar Underlying Ceusa (Disease or Injury that Initiated evants resulting In daath) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRMIC OBSTRUCTIVE PULMONARY

RACHEOBRINGHITIS R STERCHEMY)

24a. Wes an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of daath?

3 Probably 4 Unknown

1 Yes No

26. Place of Death (Check only ona)

1 ☐ Yes 2 Z No

25. Was casa referred to medical axaminar? 1 Yes 2 No

5 Pending investigation

28a. Date of Injury (Month, Day Yaar)

Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA

28b. Time of

Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 28c. Injury at Work?

28d. Dascribe how Injury occurred 2 No

28a. Place of Injury - At homa, farm, straat, factory, office building, afc. (Specity)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar

27. Menger of Death

1 Neturel 2 ☐ Accident

3 Suicida

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, daeth occurred at tha tima, data and place, and dua to the causa(s) and manner as stated.

| Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the causa(s) and manner stated.

29b. Signeture end titla of cartifier

29c. Licansa number

29d. Date signed (Month, Day, Yaar)

23b. Did tobacco use contribute to the cause of death?

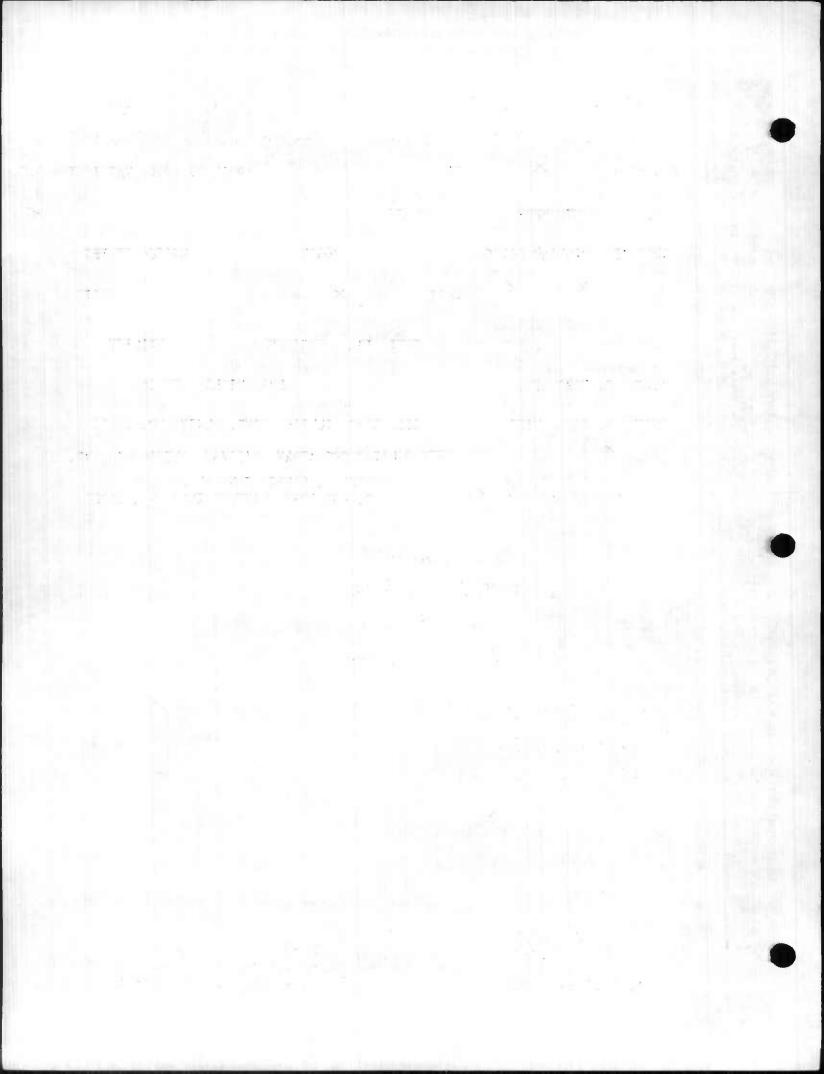
30. Neme end address of person who complated causa of daath (Item 23a) (Type, Print) HOSPITAL WASHINGTON ACCENTIST

6 Could not be detarmined

7600 CARPOLL AUGNUE MARTIAND

DR. Robert TobiN

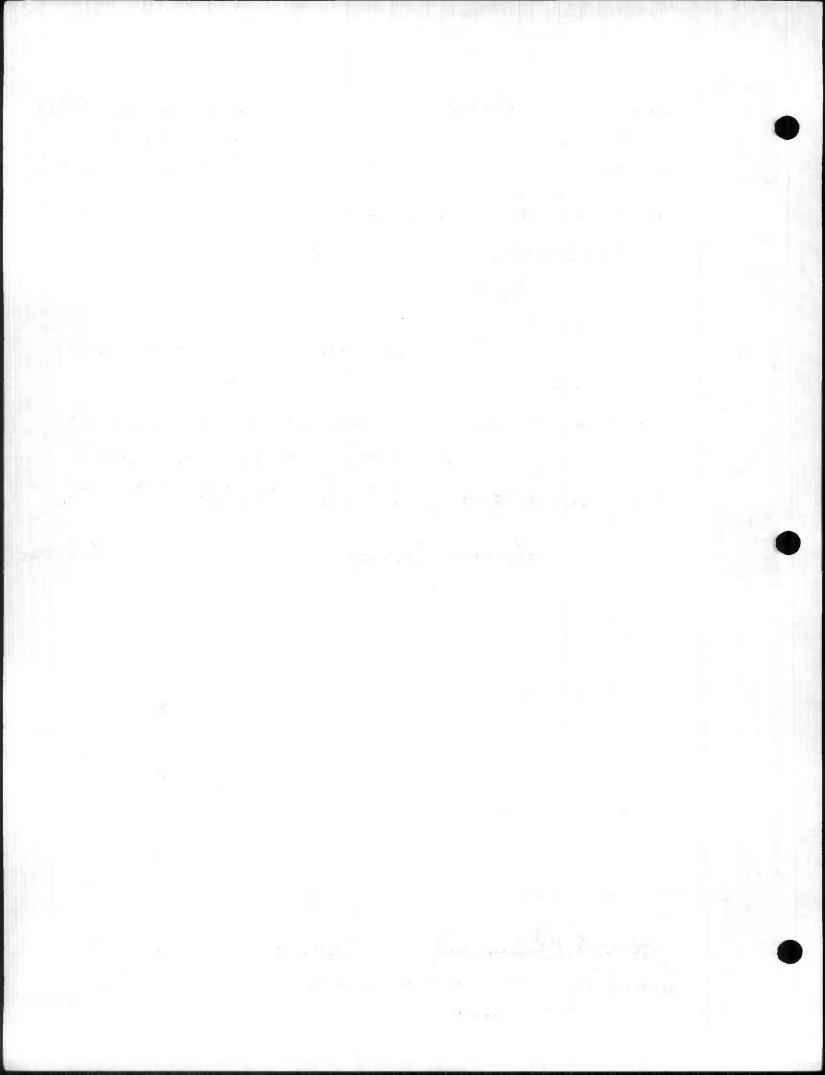
State Registrar 31. Deta filed (Month, Day, Year) JUN 21 1999 32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** 0810 JUNE MAZUC 1999 22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY 8. Date of Birth Month, Day Year) If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 7. Aga (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Deys Hours Months 1 □ M 2√2 F Yrs. WASHINGTON, DC 216-64-4098 29 Director Usuel Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. inside City Limits ortant: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examinar must be nother at 28a-f show MARYLAND MONTGOMERY SILVER SPRING Yes 2 No Director 10e. Street end Number 10f, Zip Code 10g. Citizen of Whet Country? With 707 HILLSBORO DRIVE 20902 UNITED STATES Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Yaer or Dates: Wes Dacedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Maxican, Puarto Rican, etc.) Reca - American Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic avant 1 X Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: þ 3 Widowed 4 Divorced WHITE Completed 16e. Decedent's Usuei Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Induatry Elementery/Secondery (0-12) College (1-4 or 5+) CONTRACT WORK SHELTERED WORKSHOP 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be HILDA TOMAR FRED EDERER 2 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRED & HILDA EDERER (PARENTS) 5504 LAMBETH ROAD - BETHESDA, MARYLAND 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burlel 2 □ Cremetion 3 □ Removal from State JUDEAN MEMORIAL GARDENS 6/27/99 OLNEY, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecilit DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852 23a. Pert1. Enter the disease, or complications that caused the dear Do not enter the mode of dying, such es cerdiac or respiretory arrest, shock, or heert feilure. List only one ceuse on each line. Approximete nterval Between **Physician** HODGKINS DISEASE /Medicai Immediate Ceuse (Final 6 MONTHS disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner The law requires that the death certificate be executed burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting In deeth) Lest Due to (or es e consequence of): and physician a s the burial Box 68760. Physician/Medicai Due to (or es e consequence of): Po P.O. | signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown Records, by 24b. Were autopsy findings evelleble prior to completion of cause of deeth? 24a. Wes an autopsy performed? Completed peen page 2 has 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? After 5 Pending investigation Neturel s after death. 1 ☐ Yes 2 ☐ No 2 Accident in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide Medicai to certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) end menner as aleted.

□ Madical Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier pletely 296 Signifule and title of certifier 29d. Date signed (Month, Day, Yaar) 29c. License number JUNE 22, 1999 deeth (Item 23e) (Type, Print) 7 MEDICAL CENTER DRIVE, ROCKULLIE MARYLAND 31. Dete filed (Month, Day, Year) State **JUN 25** Registrar



Physicia /Medic Examin

Funeral **Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item a 23 or 28=f show any injury or other traumatic event, the Medical Examinal must be notified at

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please T	State of Maryland		of Health a			9 21530
1. Decedent's Name (First, Middle, Last) Dona E •	Ferguson			Mon	of Death	Year 3. Tima of Death 7:05 P.M.
4a Facility Name (If not institution, give s Prince George's Ho	·		, i	wn, or Location of verly	Death 4c. Cou	nty of Death nce George's
5. Social Security Number 223-94-8137 6. Sex	7. Age (In yrs. last 40	Yrs. If Under 1 Months I	Year If Under Days Hours	24 Hrs. 8. Date Min. (Mon	of Birth	9. Birthplace (State or Foreign Country) Dover, DE.
Usual Residence of Decedent 10a. State 10b. County VA •		own or Location				10d. Inside City Limits 1 ☐ Yes 2 [X] No
10e. Street and Number 8206 Ackley St		10f. Zip C	ode 309			of What Country? ed States
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	I2. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	13. Was Deceder If Yes, specify	Cuban, Mexican	gin? (Specify Yes , Puerto Rican, et	c.) E	tace - American Indian, Black, White, etc. City: black
15. Decedent's Educ (Specify only highest grade Elementary/Seeondary (0-12)	cation 1 e completed) College (1-4or 5+)	6a. Decedent's Usual C (Give kind of work iffe. DO NOT use Stock C	done during mos retired)	of working		Business/Industry
17. Father's Name (First, Middle, Last) Joseph Randol	.ph	JOOK C.	18. Mothe	r's Name (First, A	fiddle, Maiden Sum Overto	pame)
19a. Informant's Name/Relationship (Type Caron Tolton	pe, Print)	19b. Meiling Address (5 6923 Hal	Street and Number	or or Rural Route i	Number, City or Too Ke, VA.,	wn, State, Zip Code) 22015
23a. Part1. Enter the disease, or complishock or heert failure. List only on	Henry Mor	INC.,	rt Address of Facilit 420 H	yB. K. St., N.E	HENRY F., Wash.	xandria, VA. UNERAL CHAPEL ,D.C.,20002
Immediate Cause (Finel disease or condition resulting in death)	Gast	of Wours of consequence of):		Ches	,	Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		a consequence of):				
Part it. Other significant conditions con	tributing to death but not resultin	ng in the underlying cau	se given in Part I	236	Did tobacco use	contribute to the cause of death? 3 Probably 4 Unknow
				24a	. Was an eutopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
X 105 2LINO		/Outpatient 3□ DOA	Other: 4 Nu	of Death (Check	only one) Residence 6 🗆	Other (Specify)
27. Manner of Death 1	28a. Dete of Injury (Month, Day Year) 28e. Place of Injury - At home building, etc. (Specify)	820 1	tnjury at Work? 1□ Yes 200	No Sul	cribe how injury occiling the state of the s	curred LSF Imber or Rural Route Number, Mill RD 2024
	Iclan: To the best of my knowled er: On the basis of examination and manner steted.	and/or investigation, in			time, date and place	
30. Name and address of person who cou	moleted cause of death //tem 23	to) (Time Brint)	O.C.M.E	1 •	June	17, 1999

To the Hospital or Attending Physician: The law requires that the death certificate be assocuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

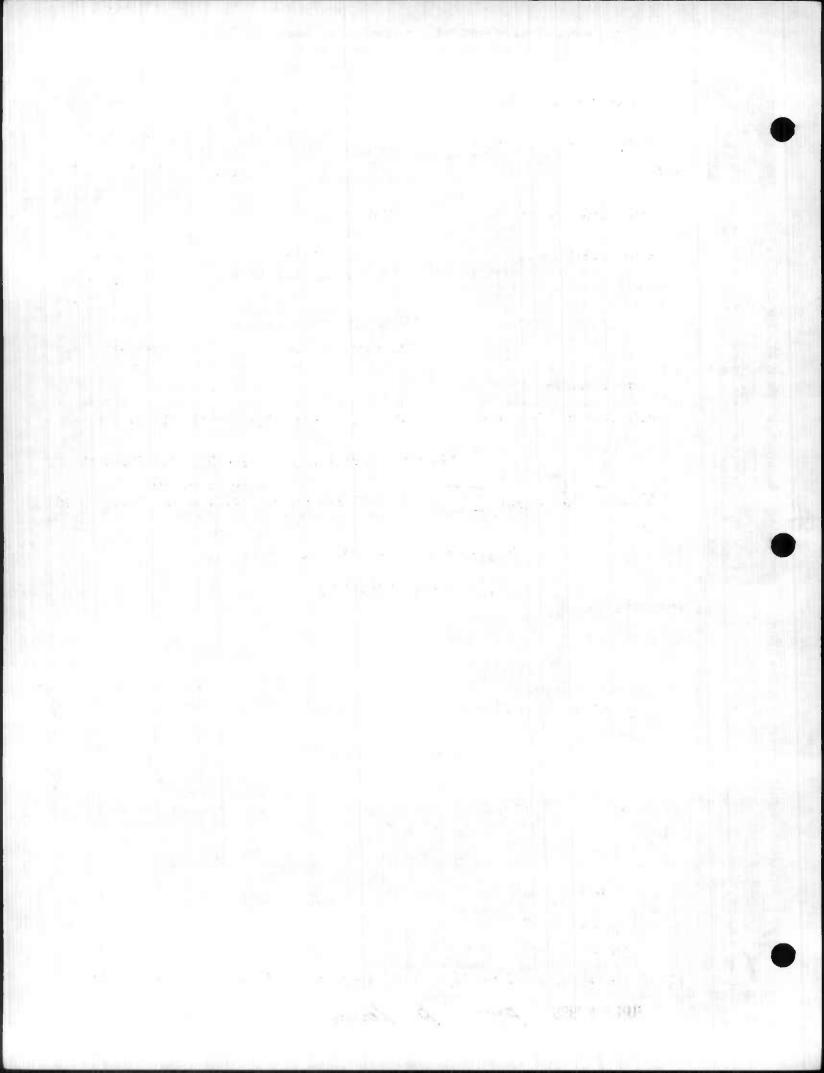
31. Date filed (Month, Day, Year)

JUN 2 4 1999 82. Registrar's Signeture

111 Penn Street, Baltimore, Maryland 21201

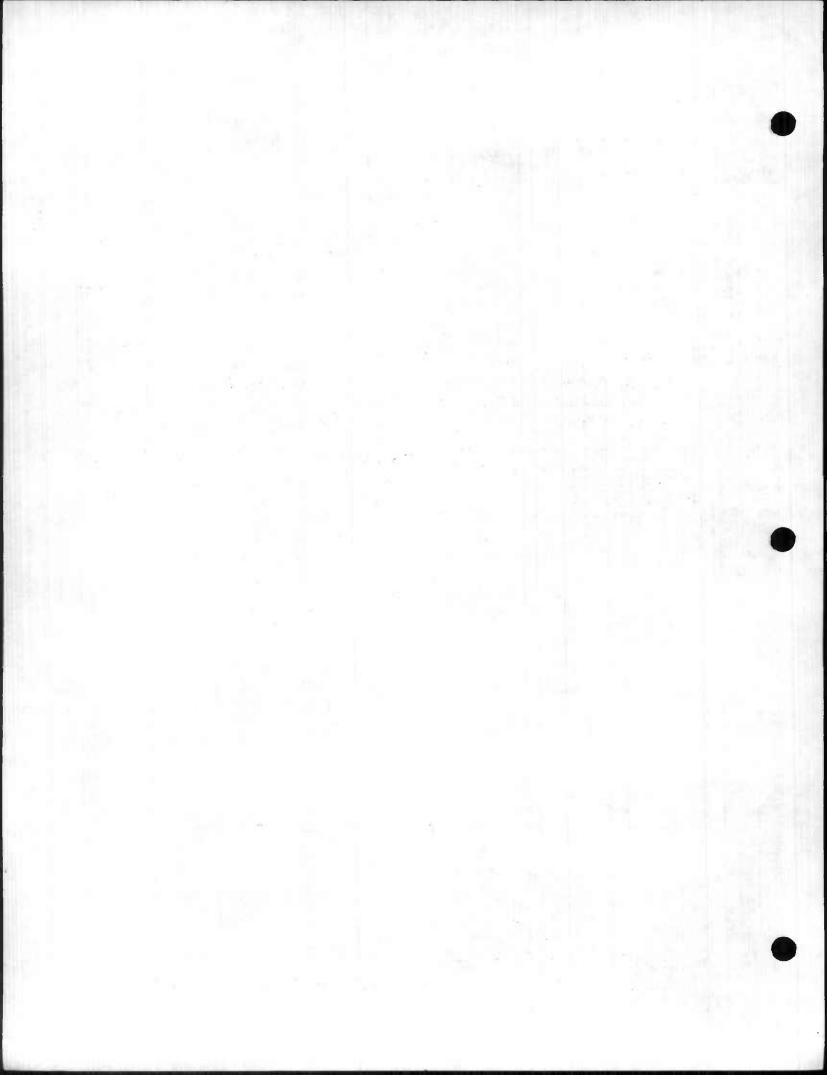
State of Maryland / Department of Health and Mental Hygiene 99 21531

						Cer	tificat	e of	Death		R	eg. No.		. 1001
			1. Decedent's Neme (First, Middle, Le	nst)							2. Dete of Deet	th	Vene	3. Tims of Death
	Physiciar /Medica		Howard Rich	ard Foste	er						June	21 1	Year 1999	1300PM
	Examine	_	4s Facility Neme (If not institution, gir	ve street and numb	per)				4b. City, To	wn, or Lo	cation of Deeth	4c. County	of Deeth	
4			Prince George	's Hospit	tal				Che	ever1	-у	Princ	ce Ge	orge's
	Funeral		5. Sociel Security Number 6.	Sex 7.	Age (In yrs. last	birthday)	If Under				8. Date of Birth	Veesl	9. Birthp	lece (Stete or Foreign try)
L	Director	-	578-20-5265 Usuel Residence of Decedent	10XM 2□F	74	Yrs.	Months	Deys	Hours	Min.	8. Date of Birth (Month, Day, Nov. 13	, 1924	Wash	., D.C.
	Mand Mand		10e. Stete 10b. County		10c. City, To	own or Loc	cation						1	0d. Inside City Limits
	he Man	2	Maryland Prince G	eorge's		Ну	atts		le					1 Ves 2 No
	23a or 2	rai Diri	10e. Street end Number 4708 - 68th A				10f. Zip		20784				ited	States
Maryland 21215-0020	urs e	by runeral	11. Maritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Types 2 If Yes, Give Year or Date	es? No		Vas Deced Yes, spec				ecify Yes or No- Rican, etc.)	Specify	ck, White	an Indian, Pican erican
5-0	72 hc	100	15. Decedent's E (Specify only highest gr	ducetion	10	6e. Deced	ent's Usue	el Occu	petion	t of worki	ina	16b. Kind of B	usiness/Inc	lustry
21	ithin	Completed	Elementary/Secondary (0-12)	College (1,-4	or 5+)				during mos	t or work	''y	C		
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pu	should be filed withind Mental Hygiene. merked other than metic event, the M	00	17. Fether's Neme (First, Middle, Last	,					18. Mothe	er's Neme	e (First, Middle, M	Maiden Suman	ne)	
yla	Men Men arke	2	Ernest Foste	r					W	ilhe	lmina Bo	oozer		
Mar	" 2 - 3		19a. Informent's Name/Reletionship Marcia Foster -				_				al Route Number ttsville			
e,	f Healt frem 2 other	-	20e. Method of Disposition	Dadgiicei	20b. Plece				Ave.,	пуа		20c. Location	20784	
Baltimore,	permit. Pages 1 end 2 Depertment of Health e Important: If item 27 is any Injury or other tra DNCs.		1 Burlel 2 Cremetion 3 4 Donetion 5 Other (Speci		ete ceme	etery, crem	atory or o	ther pla	Cem.	6	/24/99	Suitl		
alt	y inte		21. Signetury of Funerel Service Lice	nsee A	1	22	. Name en	nd Addr	ess of Fecili	ly				
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		\forall	23a. Part Enter the disease, or com	plications that cau	sed the death. D	o not ente	er the mod	le of dy	ing, such as	cardiac	N.E. Wa	asn., D	. C.	20019 Approximate
	Physician	П	shoot or heart failure. List only	one ceuse on eec	n IIne.									Onset end Deeth
)(/Medicai		Immediete Ceuse (Final	LATIA	echbor d	n	ve tra	04	end he	0,				
	Examiner		disease or condition resulting in deeth)	e. / / / / /	Duntalara	1 / /	uenes eft	× 12	INC	u	HUP		1	
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o,	an en riel-tr	LX	Sequentially list conditions, if sny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events		540 (0 (0) 05	0 0011004	d01100 017.						1	
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Vital Records,	The law requires ate has been so page 2 should										24e. Was e perforr		ev	ere autopsy findings sileble prior to mpletion of ceuse
ec	hes by	2										. 1		deeth?
<u>~</u>	The la	5									1 🗆 Ye	es 2 No	10	Yes 2 No
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n of	ding Ph. After th funeral		27. Manner of Deeth 1 ■ Naturel 5 ■ Pending	28e. Dete of (Month,	Injury 28I Day Year)	b. Time of Injury	2	8c. Inju	ury et ork?		28d. Describe ho	ow Injury occur	red	
Sio	Attending in death.	200	2 Accident investigation				М	1[Yes 2					
Division	Prospital or Attending P 24 hours effer death. Funeral Director: Affer tetely filled in by the funeral Classics.		3 Sulcide 6 Could not to determined	286. Piece of	Injury - At home, , etc. (Specify)	, ferm, stre	et, fectory	y, office			28f. Location (Si City or Town		ber or Rura	I Route Number,
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			Wyliam Boy	e PG	· Hosp	300/	110	Sp	52	Che	netly i	mo s	078	Í
	State Registrar		31. Date filed (Month, Day, Year) (JUN 2 2 1999	32. Reg	listrer's Signature	4.	bon	4	-					



State of Maryland / Department of Health and Mental Hygiene

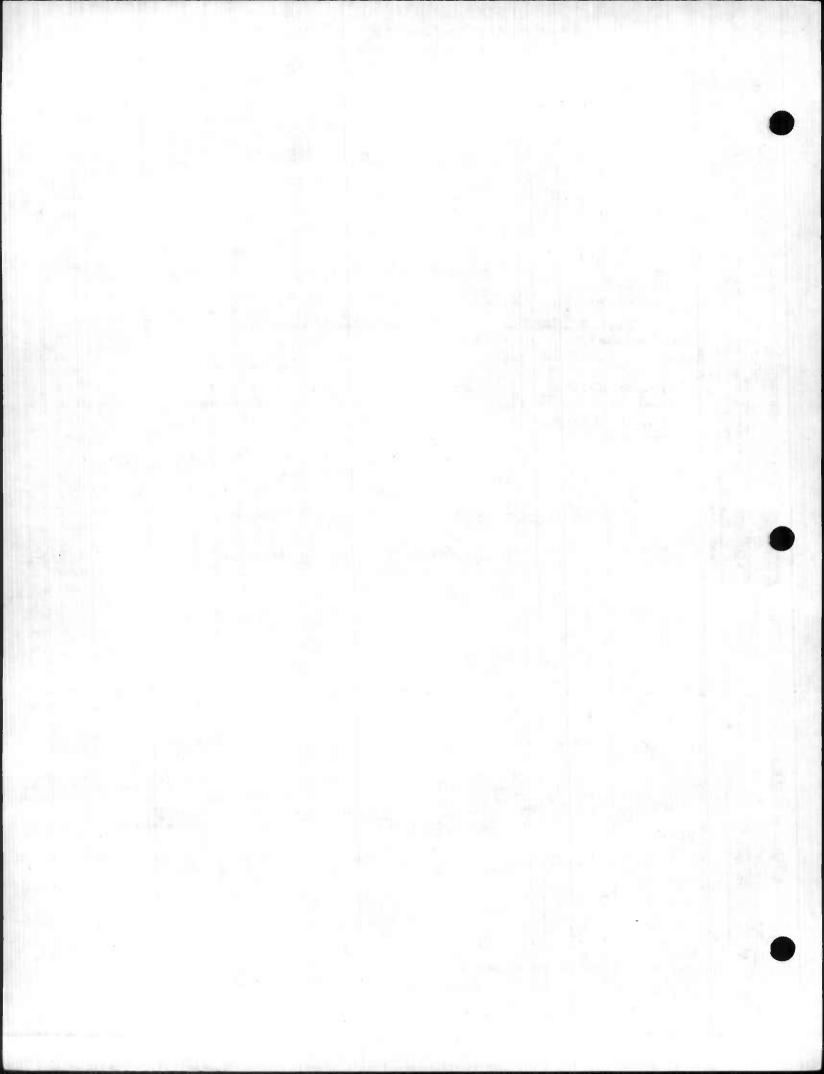
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** LOLA MAE **FORSYTH** JUNE 21, 1999 10:30 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES 3495 ELSA AVENUE WALDORF If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JULY 23, 1 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10 M XXF Days Hours Months 1915 PENNSYLVANIA 199-03-6032 Director 83 Usual Residence of Decedent the Manyland 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show mant be notified at 1 Yes 2(XNo Director WALDORF MARYLAND CHARLES 10a, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 U.S.A. 20603 3495 ELSA AVENUE 234 Funeral death Herna 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or hen any Injury or other traumatic event, the Medical Experiment Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: WHITE Specify à 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) WILLIAM YEAGER CLEMENTINE BRUCH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3495 ELSA AVENUE, WALDORF, MARYLAND GARY R. FORSYTH/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State
4 Donation 5 Other (Specify) 6/25/1999 BRENTWOOD, MARYLAND LINCOLN CEMETERY 21. Signature of Funeral Service Licenses THE HUNTI FUNERAL HOME, INC. u JOHN P. KNISLEY M01164 P.O.BOX 156, WALDORF, MARYLAND 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Arteriosclerotic cardiovascular disease **Physician** /Medical Immediate Cause (Final e disease or condition resulting in death) Examiner Coronary heart disease Examine she of) ntially list condition leading to immedi Enter Underlying (Disease or injury cerebral vascular accident Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? Division of Vital Records, P.O. È 1 Tes 2 No 3 Probably MYUnknown aigned t à Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yes 2 XXVo 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 | Nursing Home 5 | Assidence # | Other (Specify) Certification: To 1 Yes 2 PNo 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DUA å Manner of Death XXNetural 28d. Describe how injury occurred a Hospital or Attending P 124 hours after death. a Funeral Director: After the Matery filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Affair 5 Pending 1□ Yes 2□No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours after To the Funeral Dir ILX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a, Certifier er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and granner stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) DO1332 JUNE 22, 1999 arson who completed cause of death (Item 23a) (Type, Print) ROBERT DEITZ, MDM 5711 SARVIS AVENUE, SUITE 100, RIVERDALE, MARYLAND 20737 Year) State Registrar



State of Maryland / Department of Health and Mental Hygiene

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			1. Decedent's Name (First, Middle,	Last)							2. Date of D			3. Time of Death	
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	/Medica Examine		4a Facility Name (If not institution, g	rive street and nur	nber)				4b. City, To	wn, or Li	ocation of Dea	ith 4c. Cor	unty of Death	h	
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-	Funeral			_	7. Age (In yrs	. last birthda		r 1 Year		24 Hrs.	8. Date of 8	irth	9. Birtt	hplace (State or Foreign	
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	and and	-	10a. State 10b. County		10c. C	ity, Town or	Location							10d. Inside City Limits	
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2	2 should and Meni la market	-	19a. Informant's Name/Relationship			19b. Ma	iling Addres	s (Stree	and Numbe	er or Rur	al Route Num	ber, City or To	wn, Stata, Z	Tip Code)	
<u> </u>			Nelson J. Ferrag									Spring			
o o	Health Health Hem 27 I	-	20a. Method of Disposition	, ac / bon		Place of Dis	position (Na	ma of				7	on - City or		
Baltimore,	permit. Pages 1 and Department of Health Important: if item 27 any Injury or other ti ptics.		1 Buriat 2 □ Cremetion 3 4 □ Donation 5 □ Other (Special Control of the Con		State	te of	Heave	n Ce	meter	у	un 22 1999	Silve	r Spri	ng, MD	
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	icate be asscuted physician and s the burial-transit	Examiner	Sequentially list conditions,	0.	TO NAIN Due to	or as a cons	equence of)							9	
ó	an a nial-		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				•						1		
68760,	te b	Medical	that initiated events resulting in death) Last	c	Due to (or as e cons	equence of):	_					1		
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ň	attending	Physician	De All Other desidence	***							l ant mi	44-6		A- 44 4 44 44	
J.	y the	38	Part II. Other significant conditions			suiting in the	underlying	cause gi	ven in Part I			* 4		to the cause of death	
<u> </u>	requires that the death certificate be assected seen signed by the attending physician and should be detached for use as the burial-transit	7	Diabetes / Rheumatoid	Mellita	5						1	Yes 2 1	lo 3 Pr	robably 4 Unknow	
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\leq	Direction	E E	4 Homicide	buildir	of Injury - At I ng, etc. (Spec	ify)					City or T	own, State)			
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	To the Hospital or I within 24 hours after To the Funeral Dire completely filled in b		29b. Signature and title of certifier	and manr	er stated.		20	c Licen	te number			20d Data a	oned #4oct	h Day Yearl	
	5 ¥ 5 8										29d. Date signed (Month, Day, Year)				
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	1		30. Name and address of person wh				e, Print)		Chasi						
			5530 Wiscon	nsin Ave	Suite	1045	Ch	unx	Chas	m	D				
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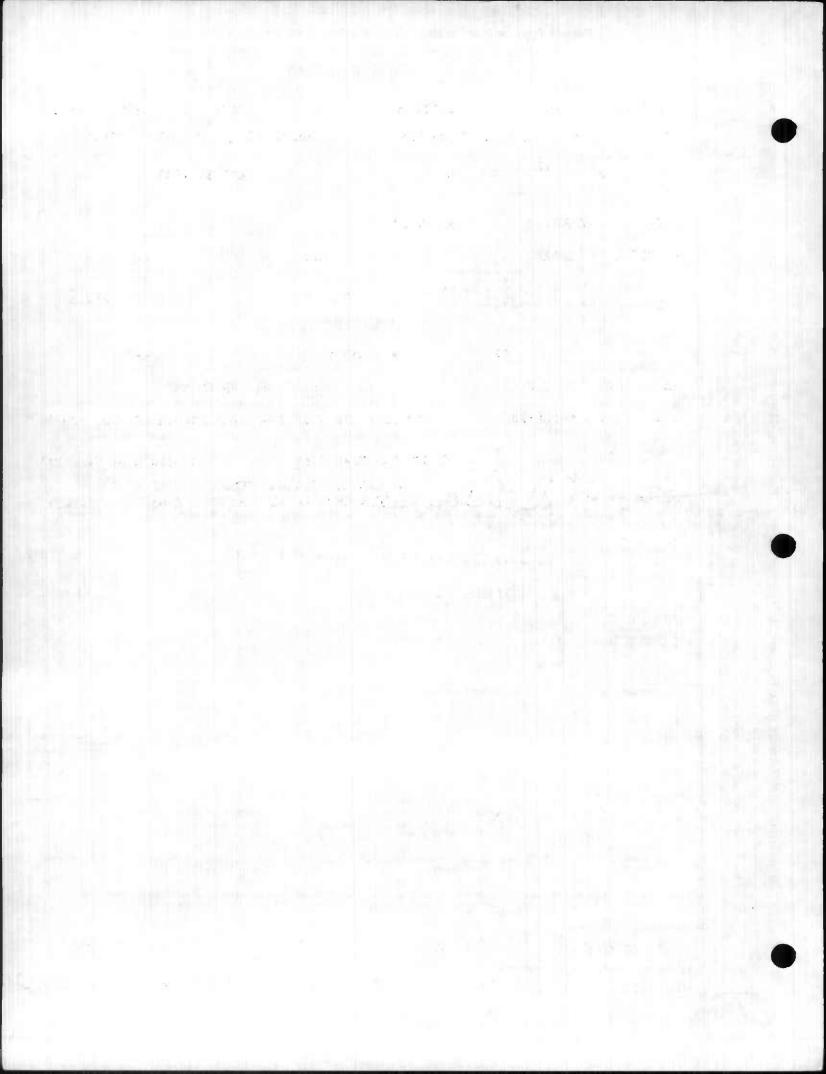


State of Maryland / Department of Health and Mental Hygien

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Physician (Madical	ARTHUR M. FRUTKIN		JUNE	Day Year 18 1999		5:23AM						
/Medical Examiner		4b. City, Town, or Lo Rockvil.	ocation of Deat	h 4c. County	of Death	1						
Funeral	Social Security Number 6. Sex 7. Age (in yrs. last birthday) If Under 1 Year		8. Date of Bir (Month, Da	irth 9. Birthplaca (St		placa (State or Foreign						
Director	281 12 6540 XXM 2□ F 90 Yrs. Months Days Usual Residence of Decedent	Hours Min.	AUG 30									
h the Maryland r 28a-f show incitied at frector	10a. State 10b. County 10c. City, Town or Location MARYLAND MONTGOMERY GAITHERSBURG		10d. Inside City Limits 1 ☐ Yes 2 ☑ No									
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urs efter hr, or he branche by Fur	Armed Forces? If Yes, specify Cub	 Was Decedent of Hispanic Origin? (Spec if Yes, specify Cuban, Mexican, Puerto R □ Yes Mo Specify: 			ck, White, etc. WHITE							
ed within 72 hours ef ygiene. wr then "natural", or nt, the Modical Exerci- Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)			d of Business/Industry							
ed w ygien f, fr	5+ ATTORNEY	L		L.A								
be filed htal Hygied other event, the	17. Father's Name (First, Middle, Last) JACOB WILLIAM FRUTKIN	18. Mother's Nam			10)							
d 2 should be the and Ments 7 is marked traumatic e		MARY H.	ERSHO		State 7in	Code)						
alth ar 27 is			ral Route Number, City or Town, State, Zip Code) ITHERSBURG. MARYLAND 20878									
if item 2	20a. Method of Disposition 1 Burlal 2 X Cremation 3 Removal from State 20b. Placa of Disposition (Name of cemetery, crematory or other place)	ace)	Date	20c. Location -	. Location - City or Town, State							
	4 Donation 5 Other (Specify) MT COMFORT CREMA!	TORY 6,	/19/99 ALEXANDRIA, VIRGINIA									
Department Personal Information Informatio	21. Signature of Funeral Service Licensee 22. Name and Addr. DANZANSKY	ess of Facility	MEMORTA	I. CHAPEI	SIN	C						
205 20-	DANZANSKY GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852											
Physician /Medical	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line.	ing, such as cardiac	or respiratory a	arrest,		Approximate interval Between Onset and Death						
Examiner	Immediate Cause (Final disease or condition a Intracranial hemorrhage resulting in death)											
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t the de tached tached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause gi	23b. Did tobacco use contribute to the cause of dea										
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The law requires that the rate hes been signed by the page 2 should be detach.		24a. Was	s an autopsy formed? 24b. Were autopsy findir available prior to completion of cause of death?									
The law requires the law requires the page 2 should be Completed by			10	Yes 200	11	Yes 200						
ysician: The s certificate director, pag	25. Was case referred to medical 26. Place of Death (Check only one)											
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or Attantest of Attantest of Attantest of In by the	2 Accident investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	t be 28e. Place of Injury - At home, farm, street, factory, office				281. Location (Street and Number or Rural Route Number, City or Town, State)						
To the Hospital or Attantowithin 24 hours after deal To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
1	29b. Signature and title of cartifier 2. Tomsko, MD 29c. Licen	51916	29d. Date signed (Month, Day, Year) Tune 18, 1999									
φ	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia L. Tomsko, MD, 11140 Rockville Pike, #348, Rockville, MD 20852											
State Registrar	31. Date filed (Month, Day, Year) JUN 2 1 1999 32. Registrar's Signature G. Sports											

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death June 15, Day 1999 **Physician** John Samuel Gabbert 4:00 P.M. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery County If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 12, 19 9. Birthplace (Stata or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Days Hours Months MM 2DF 232-16-3413 83 1916 West Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d Inside City Limits 1 Yas 2 No Director Maryland | Montgomery Olney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 19400 Olney Mill Road 20832 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forces? Yes 2 No If Yes, Give 1 ☐ Never Married 2X Married 1943 1 ☐ Yes 2 ☐XNo Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced 1945 Year or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mother's Nama (First, Middle, Maiden Surnama) 17. Father's Nama (First, Middle, Last) 89 Samuel Gabbert Bessie Wise 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John K. Gabbert/ 19400 Olney Mill Road, Olney, Maryland 20832 Son 20c. Location - City or Town, State Lewisburg, 20a. Mathod of Disposition 20b. Place of Disposition (Name of cematary, crematory or other place) June 19 1 ABurial 2 Cremation 3 Removal from State Greenbrier Memorial Gardens 1999 4 ☐ Donation 5 ☐ Othar (Specify) West Virginia 21. Signafure of Funeral Sarvice Licensee 22. Nama and Address of Facility
McCraw Funeral Home #M00690 24901 304 Courtney Drive, Lewisburg, West Virginia ascul 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final Respiratory Failure 3 Days diseesa or condition rasulting in death) Due to (or as a consequence of): Examiner Congestive Heart Failure 6 Months Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Arteriosclerotic Heart Disease Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Chronic Renal Failure/ Dialysis þ 24b. Were eutopsy findings available prior to 24a. Was an autopsy Completed Transitional Cell Cancer of Bladder completion of cause of death? 1 Yas 2 No 1 ☐ Yas 🎾 No 25. Was casa refarred to medical axaminar?
1 ☐ Yes 2 No Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28h Time of 28c. Injury at Work? 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signature and tale of centil 29c. License number 6-24-99 D05809

The law requires that the death certificate be executed physician and is the burial-trans P.O. Box 68760. 88 for use as 2 signed b Records. Deed page 2 s certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

Funeral

Director

28a-f show the Maryla

"natural", or hams 23s or

filed within 72 hours after Hygiene. other than "natural", or its

permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hygis Important: If hem 27 is marked other I any injury or other traumatic event. th

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

State Registrar

15

31. Data filed (Month, Day, Year) JUN 2 4 1999

John G. Lodmell, M.D. 32. Registrar's Signature Sepera

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2901 Olney-Sandy Spring Road, Olney, Maryland

301-774-6655

						y rour it		epartment o Certificate o				Reg. No		(m)		
	Physici /Medic							June	June 20 1			3. Tim				
	Examin	_		'If not institution, give						b. City, Town_or			County			
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		15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+)			. 5.)	18a. D	18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of Business/Industry				
		12	ondery (0-12)	College (1-4or	r 5+)	Construction Foreman					Private					
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	and and and and and and and and and and			ame/Relationship (Mississ								0032
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Carri	Department of Important: If eny injury or pace.		4 Donation 5 Other (Specify) Ft. Lincoln Cemetery 6/23/99 Bren 21. Signature of Juneral Service Licensee 22. Name and Address of Fecility Alexander S. Pope Funeral Hom								Ju, 11					
	Physician /Medical Examiner		5538 Marlboro Pike/Forestville, Md. 20747													
		,	23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cetise on each line. Approximate interval Between Onset and Death													
			Immediate Cause (Final disease or condition resulting in deeth) Preumonic Due to (or as a consequence ot):										-			
	outed nd ransit	Examiner	b. Bacterenia									Days				
Box 68760, teth certificate be assouted attending physician and for use as the burial-transit	8	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Cause (Disease (Disease or injury Cause (Disease (Disease or injury Cause (Disease (D							perfor	forcition			Dac	15		
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of VICAL RECOTORS, Prysician: The law requires that is cartificate has been signed buffector, page 2 should be date.	y Phys	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Niabetes mellitus, Goot, hypertension					23b. Did tobacco usa contribute to the cause of death 1 Yes 2 No 3 Probably 4 Nunknow									
	pleted b	Renal insufficiency					. ,,,	24e. V			Ves an autopsy 24th enformed?		avai	b. Were autopsy findings available prior to completion of cause of death?		
	mo									1 🗆	Yes 2	No	1 🗆	Yes 2	No	
	Bec		5. Wes case referred to medical 26. Place of Deeth (Check only one)													
	To	examiner?	No	Hospital:	tient 2 🗆 E	ER/Outpo	atient 3 DOA	Oth	er: 4 Nursing	Home 5 ☐ Res	idenca	6 □Othe	er (Specify))		
	al or Attending s after death. In Director: After ed in by the funa		27. Manner of Deal 1 ANatural 2 ☐ Accident	5 Pending investigation	Pending (Month, Dey Year) Injury Work? Investigation M 1 Yes 2 No Could not be						28d. Describe	Describe how injury occurred				
DIVISION		Certific	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined					28f. Location (Street and Number or Rural Route Number, City or Town, State)							
		edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and mannar as steled. 2 Medical Exeminer: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and mannar as steled.													
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	(5)			ress of person who	-		23e) (Ty			hael horf, 1						•
	Sta Registr		31. Date tiled (Mon			strar's Signat		Sports								
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			Decedeni's Nema (First, Midd	lo I act)		Cel	rtificate	Of L	Jeath	2. Dete of D	Reg. No.		3. Tima of Death
	Physicia	n	David Frankly							Month	Dey	Year	10:20 A.1
	/Medica	al :	4a Facility Nama (If not institution		(mharl			1	h City Town o	June Location of Dea		999 y of Death	
	Examine	r	Anne Arundel M						Annapol			Arun	
1-	E		5. Social Sacurity Number	6. Sex	7. Age (In yrs.	last birthday)	If Undar 1		If Undar 24 Hr	s. 8. Data of B	irth	9. Birth	placa (Stata or Foraign
п	Funeral Director		028 18 2426	XXM 2 F	72	Yrs.	Months I	Days	Hours Mir	June			sachusetts
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	72 hours after death with the Maryland netural", or items 23e or 28a-f show pical Examiner must be notified a		10e. Stata 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	Ba-f	Director		Arunde1	G	ambril					T		1 ☐ Yas 🍇 No
	or 2		10e. Sireet and Number	4.1-			10f. Zip C				10g. Citizan of		
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217	yiena.	E	Elementary/Secondary (0-12)	5+	(1-4or 5+)	At	torney				Law		
P	othe othe	Be	17. Fathar's Name (First, Middle,	Last)					18. Mothar's Na	ame (First, Middl	la, Maidan Suma	ma)	
<u>a</u>	uld b Mante Alante rked	0	Ernest Grant						Harrie	tt Laney	7		
Maryland 21215-0020	s 1 and 2 should be filed within 72 hours after death with the Marylar Health and Mantal Hygiene. fem 27 is marked other than "neturel", or items 23e or 28e-f show other traumatic event, the Maplest Examiner must be notified at		19a. Informant's Name/Ralation				-				ber, City or Town		
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Baitimore,			20e. Mathod of Disposition 1€ Burial 2 ☐ Cramation	3 □Ramoval from	Staia 20b. P	lace of Dispo ematary, crar	natory or oth	of ar plac) June 2	1, 1999	20c. Location	- City or T	own, State
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Sail	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Sarvice	Licensia	0	22 R	Ohert	Addras F.	s of Facility Evans F	uneral	Home, In		
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18	/Medical Examiner		Immadiata Cause (Final disaase or condition	a fit is	perco	261	L Re	spi	1003	Farly	, Dilea	1	
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	ding Ph. Aftar th funaral		27. Mannar of Death Natural 5 ☐ Pandi	28a. Date	of Injury oth, Day Year)	28b. Tima o	f 28d	. Injun	at k?	28d. Describ	e how Injury occ	urred	
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral	edical	(Check only 2 Medical	ng Physician: To the Examiner: On the b	pasis of exeminal								
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`	S T S		29b. Signatura and title of certifie								6-18		37, 100.7
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	(22) 11	4	30. Name and addrass of person	who completed cau	sa of daath (item	1 23a) (Type,	Print)		0 0	1 - 1 4			

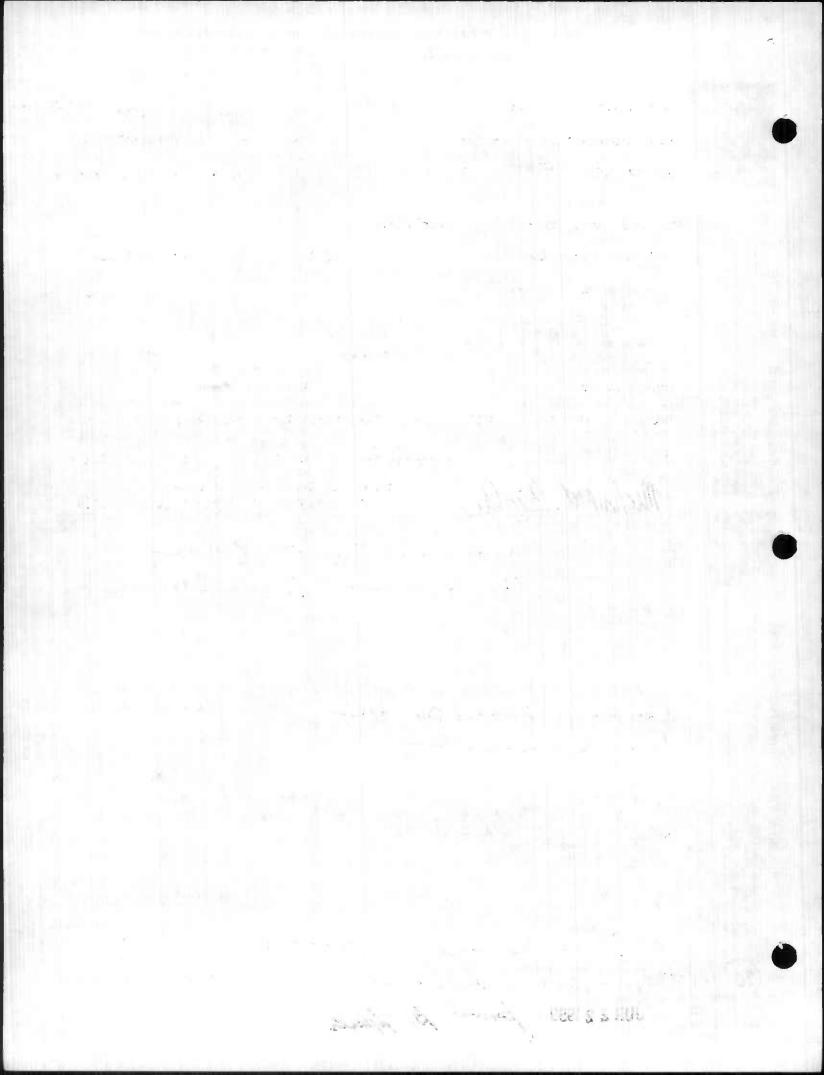
State Registrar

31. Data filed (Month, Day, Year)

JUN 2 2 1999

33. Ragistrar's Signatura

34. April 1999



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State of Maryland / Department of Health and Mental Hygiene 99 21528

				State of Mary		Certifica			J Mental II	Reg. No.	7 6	1538
	Physicia	n	1. Decedent's Name (First, Middle, Last)		G	air	ier	2. Dete of D	Days 1	79019	3. Time of Death 7:08 Am.
	/Medica Examine	_	4e Facility Neme (If not institution, give	street and number)					or Location of Dea		of Death	7
			The Johns	Hopkins	Ho	spite	1	Baltin	more.	N/	A	
	Funeral		5. Social Security Number 6. Se	X 7. Age (In	yrs. last birtl	Months	er 1 Year Days			irth Pay, Year)	9. Birthp	place (State or Foreign
	Director	-	236 66 2550 Usual Residence of Decedent	5	6'	rs.			Jan.	27,1943	Glen	Falls WV
	show show	1	10a. State 10b. County	100	. City, Town	or Location					1	10d. Inside City Limits
	May Fr sh filled	io	West Virginia Har	rison	Clark	ksburg						1 ☐ Yea 🌪 № No
	with the Marylar s or 26a-f show be notified at		10e. Street and Number			10f. Z	ip Code	06001		10g. Citizen of V	Vhat Cour	ntry?
	23s		Route 3 Box 345					26301		United	Stat	es
Maryland 21215-0020	er, o	by Fur	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	in U,S.		edent of the ecity Cub		(Specify Yes or Nuerto Rican, etc.)	lo- 14. Race Biac Specify	k, White,	can Indian, etc. iite
2-0	72 ho	pet	15. Decedent's Edu (Specify only highest grad	cation	16a. l	Decedent's Us	ual Occup	pation during most of	warking	16b. Kind of Bu	siness/In	dustry
21	The same	Completed	Elementery/Secondary (0-12)	College (1-4or 5+)		life. DO NOT	use retire	d)	WORKING			
2				0	Co	-Owner						ctro Platin
and	50 to 50 to	ã l	17. Felher's Name (First, Middle, Last) Ersel Gainer						Name (First, Middl ine Dodd		0)	
2	d Me d Me mark matic	0	19a. Informent's Neme/Relationship (T)	me Print)	10h	Mailing Addra	se (Straai		Rural Route Num		State 7in	Code)
Ma	nd 2 s ill so 77 is freu		Bonnie McVaney Ga						rksburg V			
re,	Free (Hear)	1	20a. Method of Disposition	20						20c. Location -		
Ë	Page anticit		1 ☐ Buriat 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Flora	1 Hill	s Me	morial (24, 1999 Gardens	Clarksh	nire	WV
Baltimore	Party Sparts	1	21. Signature of Funeral Service Licens		11010	22. Name	and Addre	ess of Facility		1		
m	20118	- 1	Muhail &	Sie Ves		1			Funeral I Rd. Bowie			715
		1	23a. Part1. Enter the disease, or complishock, or heart failure. List only or	icalions that caused the caused the	deeth. Do no						10	Approximate Interval Between
Ì	Physician		, , , , , , , , , , , , , , , , , , , ,									Onset end Deeth
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Dissemi	nated	Into	4 445	cular Co	agulatio	1	1	1 day
			resolding in death)			onsequence of	f):				1	
	de is de .			Sepsi:								6 days
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68760,	ficate be executed physician and is the bunal-transit	200	that inflated events	Myoco		onsequence of		tion				3 days
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0	death of for		Part II. Other significant conditions cor	ntributing to death but not	resulting in	the underlying	cause gi	ven in Part I.	23b. Die	1 tobacco use cor	ntributa t	o the cause of death?
s, P.O.	v requires that the death certiful been signed by the attending should be detached for use a	Completed by Physician/M								Yes 2□No		bably 4 Unknown
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/ita	certificate		25. Was case referred to medicai examiner?					26. Placa of I	Death (Check only	one)		
of	Physic this c	2	1 ☐ Yes 2 No 27. Menner of Death	1 Inpatient 28a. Date of Injury	2 ER/Outp		JUA		g Home 5 Res	idence 6 □Oth		(v)
00	After fund	I	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yea		jury M	28c. Inju Wo 1 [rk? Yes 2 □ No				
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	To the Neoptial or Attracting Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, pege	edical certification:	29a. Certifier (Check only one) 12 Certifying Physical Examination (Check only one)	sician: To the best of my ner: On the basis of exan and manner stated.	knowledge, nination and	death occurre /or investigation	d at the ti	me, date and plo opinion, deeth o	ace, and due to the courred at the time	e cause(s) end ma e, date end place,	nner as s and due to	iteted. o the cause(s)
	To the		29b. Signature and title of certifier				-	se number		29d. Date aigner	d (Month,	Day, Year)
			1 Lyneson	() (m.	D.		RE	5-00	0	6/19	7/9	19
	(10)		30. Name and address of person who co	mpleted cause of death (White	Item 23a) (T	(ype, Print)	Hoo	kins H	tospital	Baltimo	re, N	Tary land
j	State Registra	-	31. Dete filed (Month, Day, Year)	32, Registrar's S		do	-	,			,	

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_				ificate of			Reg. No.	2 6	1539
В	Physic	ian	1. Decedent's Name (First, Middle, Lest) Rernice Green			2. Dete of De Month	Dey	Year	3. Time of Deeth
Я	/Medi	cai	BERNICE CTREEN 4e. Fecility Neme (If not institution, give street and number)		4h City Tour on La	June		L I	1250 PM
a	Exami	ner	Mariner Health Center		4b. City, Town, or Lo		,	of Deeth Se Geor	cale
Н	Funerai	г		If Under 1 Year	if Under 24 Hrs.	8. Date of Birt (Month, De			_
	Director		579–38–4787 1□ M 2 ^M F 68 Yrs.	Months Deys	Hours Min.	(Month, De	y, Year) 29,1930	Country Washir	e (State or Foreign) ngton, D.C
	yland		10a. Stete 10b. County 10c. City, Town or Loca	ation				10d	inside City Limits
	Mar	tor	Maryland Prince George's District	Height	S				Yes 2□No
	or 28	Olrec	10e. Street end Number	10f. Zip Code			10g. Citizen of \	Whet Country	?
	23a	ral	7005 Kipling Parkway	2	0747		U.S.A	۸.	
21215-0020	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental thygiana. If item 27 is marked other than "natural", or items 23a or 28a-f show or other treumatic event, the Medical Examinar must be notified at	by Funeral Director	1 ☐ Never Merried 2 ↑ Married 1 ☐ Yes 2 ② No	es Decedent of H res, specify Cubo Yes 2 No	dispenic Origin? (Spien, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Specify	e - American ck, White, etc	
5-0	72 ho	Completed	15. Decedent's Education 16e. Decader (Specify only highest grade completed) (Give kir	nt's Usual Occup	pation	ina	16b. Kind of B	usiness/Indus	stry
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Maryland	ouid be f Mental B arked of atic eve	Be c	James D. Ross, Sr.		18. Mother's Neme			10)	
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	1 and 2 Health a am 27 is				way, Distri				
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Ĕ	Pages nent of I ant: If its ury or o		A □ Donetion 5 □ Other (Specify) A □ Donetion 5 □ Other (Specify)			06/25 1999	Clinton	, Mary	land
Balt	permit. Pages 1 and Department of Health Important: If itam 27 any injury or other tr			Neme end Addre	ss of Fecility NS FUNERA	T, HOME			
			Nancy A. Percente 747	4 Lando	ver Road,	Landov	er, Mar		
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JH.	Physician /Medicai		Immediate Cause (Final	60	201 210 111				
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	icata be axecuted physician and s the bunal-transit	хаш	Sequentially list conditions, if any leading to immediate		C11/2 - 1/1	<u> </u>			
60,	be ay		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Priv	nory	site			
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	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth or content of the basis of exemination end/or investigation and manner stated.	ccurred et the time	ne, dete end piece, e pinion, deeth occurre	end due to the ded at the time, o	cause(s) end me dete end plece, s	nner as stete	d. a ceuse(s)
	ithin i	Med	one) end menner stated. 29b. Signeture and the of certifier	29c. Licenso			29d. Dete signed		
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	(2)	1	30. Name and eddress of person who completed cause of death (Item 23e) (Type, Prin	01) (70 -			0 - 0	2	177
			Gyan C. Surana, M.D.	585	1- Deale	- 207	51	Koad	Peale
	Sta Registra		31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture	1					

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Dev Month **Physician** LEATHA IRENE GOUGH June 22 1999 5:11 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Ye May 16, 1 Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 M 2 X F 73 May Director 515-16-7669 Kansas Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location ahow 10d. toside City Limits r than "natural", or items 23s or 28s-f ahor the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Montgomery Montgomery Village 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 20886 19056 Mills Choice Road #4 U.S.A. Funeral 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Merried 2 Merried 21215-0020 1 ☐ Yes 2 No Specify: Specify: White by 3 Widowed 4 □ Divorced Year or Detes Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Own home Homemaker Baitimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Mental Hy almortant: if item 27 Ia marked other Dany Injury or other traumatic avent E banse. Be Carrie I. Stoughton Arthur W. Hoaq 19e. tnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 20886 Wilma I. Lucas/Daughter 19056 Mills Choice Rd. #4, Montgomery Village, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ABurial 2 Cremation 3 Removel from Stete
4 Donation 5 Other (Specify) y, crematory or other place, Maryland Veterans Cem. 6-24-1999 Cheltenham, Maryland 21. Signature of Funeral Service Lice) see 22. Name and Address of Fecility The Huntt Funeral Home, Inc. mew MARK G. BROHAWN M00053 P.O. Box 156, Waldorf, Maryland 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel . Septic Shock disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner sician and burial-transit requires that the death certificate be executed Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of) physician s the bunel Box 68760, Physician/Medicai Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? á 3 Probably 4 Unknown 1 Tan 2 No Metabolic Acidosis bengis Records, p Completed 24b. Were autopsy findings available prior to 24a. Was en autopsy completion of cause of death? page 2 1 ☐ Yes 2 ☐ No 2 N certificate of Vital director. Be 25. Wes case referred to medicat examiner? 26. Place of Deeth (Check only one) Hospitet: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🖰 Inpatient 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After Division Hospital or Attending 1 DNaturel 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edical t e 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D33224 06-22-1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Ray 6/95

State

Registrar

RAM S. TREHAN

JUN 25

1999

31. Date filed (Month, Day, Year)

1150

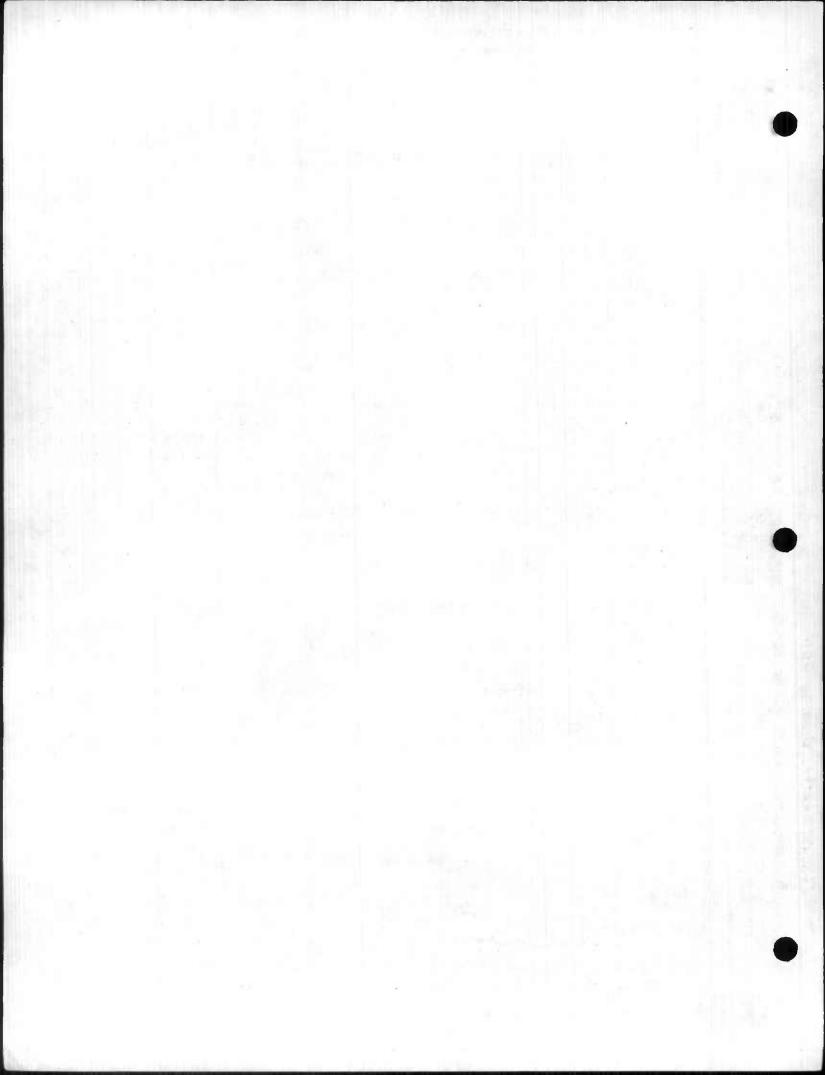
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32. Registrer's Signature

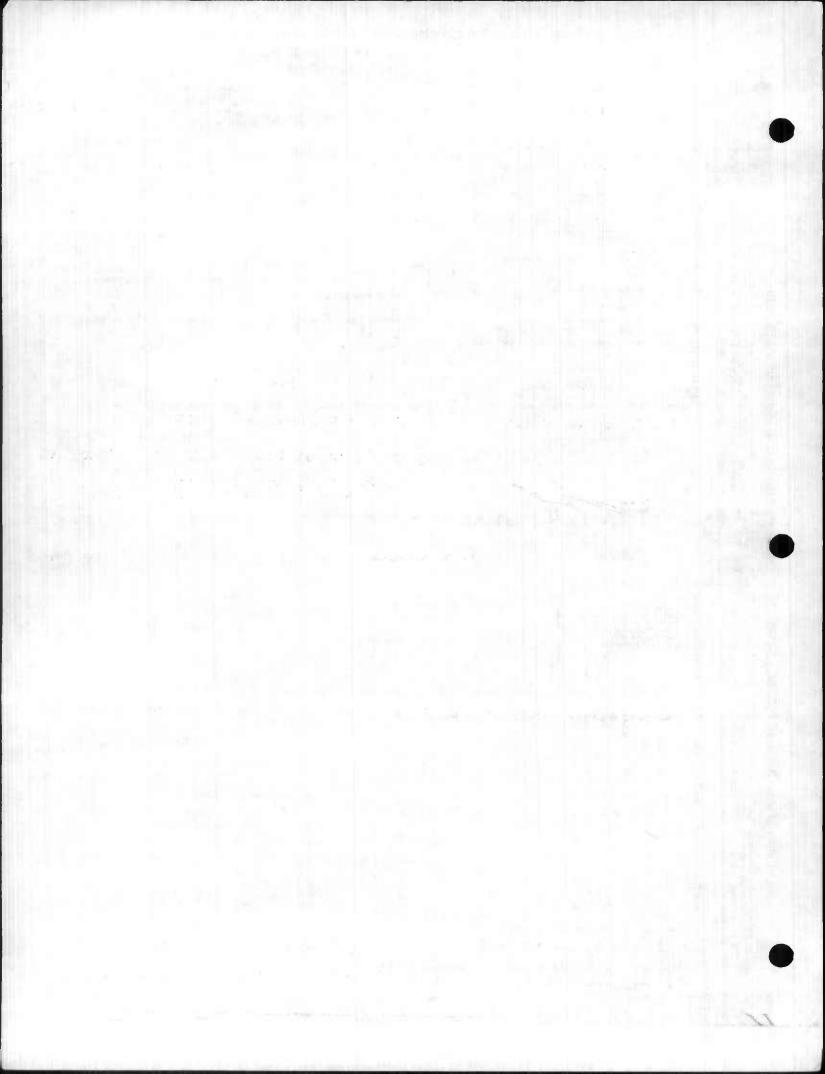
50 W Edmonston Drive, Rockville, Md



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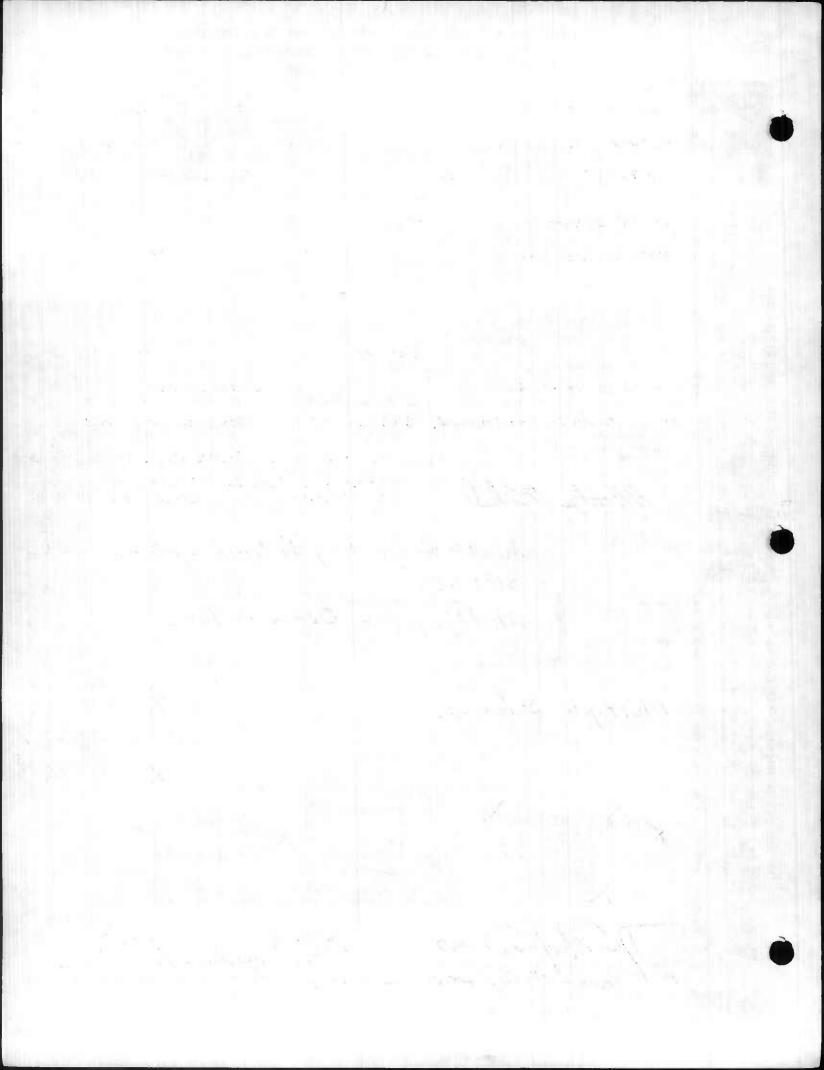
State of Maryland / Department of Health and Mental Hygiene Q Q 2 1 5 1 1

					Cer	tificate	e of	Death		Re	g. No.	64	104	
		1. Decedent's Nama (First, Midd	lie, Last)							2. Date of Death Month	h Day	Year	3. Time o	of Death
	sician edical	SOPHIE	9	ORDON	4					JUNE	20	1999	11-	1000
70	miner	4a Facility Name (If not Instituted	on, give street and numbe	r)				4b. City, To	wn, or Lo	cation of Death	4c. County	of Death		
		Hebrew Home o	of Greater W	ashingt	on			Rocky				gome	ry	
Funer Direct		5. Social Security Number 578-10-9311	6. Sex 1 □ M 2 🕶 F	Nge (In yrs. last 79	birthday) Yrs.	If Under Months	1 Yaar Days	If Under Hours	24 Hrs. Min.	8. Date of Birth	Year 1919	9. Birthp	laca (Stete Shing	or Foreign ton D
9		Usual Residence of Decedent												
nrytar show	_	10a. State 10b. County	/	10c. City, To	own or Lo	cation						1	Od. Inside (City Limits
h tha Maryland r 28a-f ehow	cto		omery	Roc	kvil	7								2 110
th with th	al Director	10e. Street and Number 6121 Mor	ntrose Road			10f. Zip (852			10	0g. Citizen of V	What Cour SA	try?	
5-0020 72 hours after death with the Maryland neturel; or items 23e or 28e-1 show	by Funeral	11. Marital Status 1 Never Married 2 Mai 3 Widowed 4 Divorce	If Yas Giva	₹No		Vas Decede I Yes, speci I 🗆 Yes 2		Hispanic Orl an, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	Blac	e - Americ ck, White, .: White	etc.	
72 hours	pet	15. Deceder	nt's Education est grede completed)	11	6e. Deced	lent's Usual	l Occup	ation	t of worki	na	16b. Kind of B	usiness/Ind	Justry	
nd 2121 e filed within al Hygiene. I other than "	Completed	Elementery/Secondery (0-12)	College (1-40	r 5+)		s Cle		during mos d)	0 40///		Reta	ail		
W 75 5 0	To Be C	17. Father's Name (First, Middle Benjamin Gev		1				18. Mothe		(First, Middle, M Mitchel		re)		
Maryle 12 should h and Mer lis marks traumatic		19a. Intormant's Name/Retation	ship (Type, Print)	1	9b. Mailin	g Address	(Street	end Numbe	er or Rure	A Route Number,	Cify or Town,	Steta, Zip	Code)	
		Anita Frankli	n-Daughter		111	Cross	St	. Lake	ewoo	d, NJ 08	701			
2 8 2 2		20a. Method of Disposition 1 2 Burlat 2 Cremation 4 Donation 5 Other (5		ceme	etery, cren	sition (Nem natory or ot id Me	har pia	ce) ial Ga	arde	Dete ns6/23/9	9 Fall:	-		VA
Baltimo pemit. Paga Department of Important: If eny Injury or	DUCE.	21. Signature of Funeral Service	Licensee		£ 1	Name and dward 091 R	Addre Sa ock	ss of Facility	inera Pike	al Direc	tion lle, M	D 208	52	
		23a. Part1. Enter the disease, o shock, or heart taiture. Lis	r Complications that caus	ed the deeth. D									Approxima Interval Be	ate
Physicia /Medic Examina	ai er e	Immediate Cause (Final disease or condition rasulting in death)	a	Pneum Due to (or as									0 D1	445.
BOX 68 / 60, leath cartificate be executed attending physician and for use as the burial-transit	×	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as							- 6.			
IS, P.O. BOX es that the death carl igned by the attending be deteched for use a	Jan		.									1		
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data data	돈	Congestive	Kent	fail	ure.					1 🗆 Yı	88 2€ No	3 Pro	bably 4	Unknown
cord requir been s should	Completed by Physician/	d								24e. Wes en	n eutopsy ned?	av	ere eutopsy ailable prior impletion of death?	rto
The law The law ata has pega 2	Eo									1 □ Ye	s 24 No	1[Yes 2	□ No
	BeC	25. Wes case referred to medical	ıl					26. Plece	ot Deat	n (Check only on	e)			
Of VICE Physician: this cartific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospitet: 1 ☐ Inpa	tient 2□ER/	/Outpatien	t 3 DO	A Oti			me 5 Reside		er (Specif	(v)	
Attending Physic death. ector: After this by the funeral di		27. Manner of Death 1 Natural 5 ☐ Pendi	28a. Date of In	jury 28	b. Time of injury		Bc. Inju Wo			28d. Describe ho			,,	
2446	Certification:	3 Suicide 6 Could 4 Homicide determ		njury - At home etc. (Specify)	, tarm, str	eet, factory,	, office			28f. Location (St. City or Town	reet end Numi n, Stete)	ber or Run	Il Route Nu	m <i>ber</i> ,
Hospital 24 hours a Funeral C lataly filled	edical 0		ng Physician: To the besi Examiner: On the besis and manner	ot exemination										(s)
To the To the To the Complet	Me	29b. Signature and title of certific	ar			29c.	. Lican:	sa number		2	9d. Date signe	d (Month,	Day, Year)	
)	1 P. Tal	a.m. m.D			3	36	552		-	JUNE	20	1999	
40	/	30. Name and address of person	who completed cause of					Ro	CKI	nue	MD.	208	52	
	State	31. Date filed (Month, Dey, Year		strar's Signature										-
	strar	JUN 22	1999	wa	9.	hon	4							



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						,	Cer	tificate o	of Death		Reg. No.	1-1-4	
			1. Decedent's Nam	ne (First, Middle, L	ast)	*				2. Data of De Month	eeth Day	Year	3. Time of Death
	Physicia /Medica		Lauriea	nn Rivki	n Greeves					June		999	1425 pm
ñ.	Examine				ive street and number				4b. City, Town,	or Location of Dea	th 4c. County	of Death	
			Montgom	erv Gene	ral Hospi	tal			01nev		Mor	ntgom	erv
	Funeral		5. Social Security N	lumber 6.	Sex 7.		last birthday)	If Under 1 Ye Months Day	er if Under 24 H	in. 8. Date of Bi	rth		olece (State or Foreign
	Director		213-78- Usuel Residance o	0091	1□M 2및F	35	Yrs.	WORLD'S Day	ys riodis w	May 3	Ten Time I		ginia
	72 hours after death with the Maryland natural', or items 23a or 28a-f show sical Examinat front be motified at	ō	10a. State	10b. County		10c. City	y, Town or Lo					1	10d. Inside City Limits 1 ✓ Yes 2 □ No
	the 1	Director	Maryland 10e. Street end Nu	Montgom	ery		Olney	10f. Zip Code	Α		10g. Citizen of 1	What Cour	ntry?
	with with				*								
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	Herri	S		ried 2 Married	Armed Force	\$7	13.	Yes, specify C	of Hispanic Orlgin? Suban, Mexicen, Pu	arto Rican, atc.)	Bla	ck, White,	
20	rs af	by	3 Widowed		If Yes, Give			☐Yes 2√21	No Specify:		Specif	whi	÷ 0
5-0020	n 72 hours aft "natural", or	D D		15. Decedent's E			16e Decec	lent's Usual Oc	cupation		16b. Kind of B		
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Maryland		o Be	011	Th D	d				A T				
7	should nd Men marke umatic	2	19a. Informant's N	Thomas R			19h Mallir	n Address /Str	eet a <i>nd N</i> um <i>ber</i> or	Orothy M		State Zir	Code)
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o o	1 and 1 Health em 27		MICHAEL 20a. Method of Dis		eeves (hu			sition (Name of		Olney,	Maryland		
Ö	Peges nent of h mrt: If he ary or of		1 ☑ Burlai 2	☐Cremation 3 l	Removal from Sta	te	emetery, cren	natory or other	place)				
ti-	tmer tant			5 ☐ Other (Spec		Gat				6/21/99	Silver	Spri	ng,Marylan
Baltimore,	permit. Peges 1 and Department of Health Important: If them 27 any Injury or other to anoce.		21. Signature of Fu	uneral Service Lice	ensee	0			dress of Facility J. Collin	s Funera	1 Home.	Inc.	
	707 a a		////	oute.	Tiho		50	00 Unive	ersity B1	vd. W. S	ilver Sr		,MD 20901
100	50. TEL		23a. Part 1. Enter t	the disease, or con	mplications that ceus y ona ceuse on eecl	sed the deat	h. Do not ent	er the mode of	dying, such es cerd	liac or respiretory	errest,		Approximete Interval Between
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00	v require been si should	Completed								pen	formed?	CO	veilable prior to empletion of cause
Se	has has	E E									(m)		death?
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Z	or Attend after death Director: A I in by the f		4 Homicide	datermine	d 20e. Place of	Injury - At he etc. (Specify	ome, ferm, str	eat, factory, offi	ice		(Street and Numi own, State)	ber or Run	al Route Number,
	rs af	S											
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completaly filled in by the funeral director.	edica	29a. Certifler (Check only one)		hyaician: To tha be iminer: On the basis end mennar	of examina							
	thin	Me	29b. Signature a go	titled centifiers	1	Sielau.		29c Lin	ense number		29d. Date signe	ed (Mooth	Day, Year)
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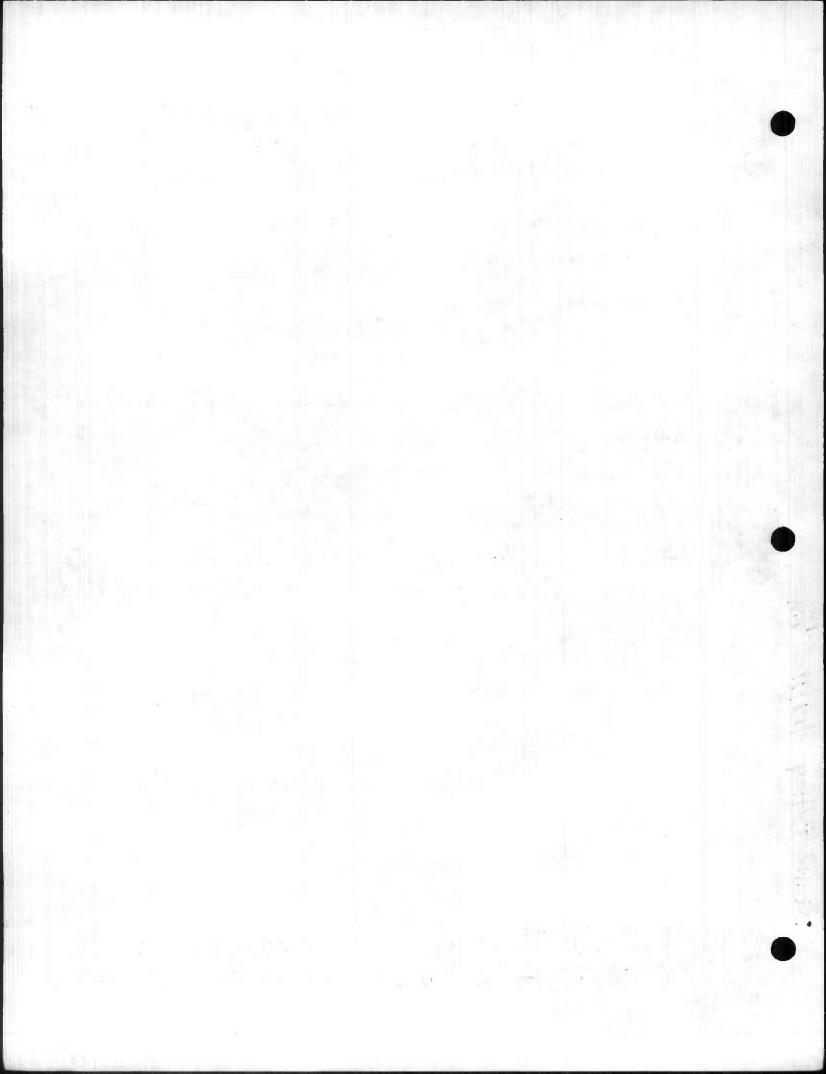


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State of Maryland / Department of Health and Mental Hygiene 99

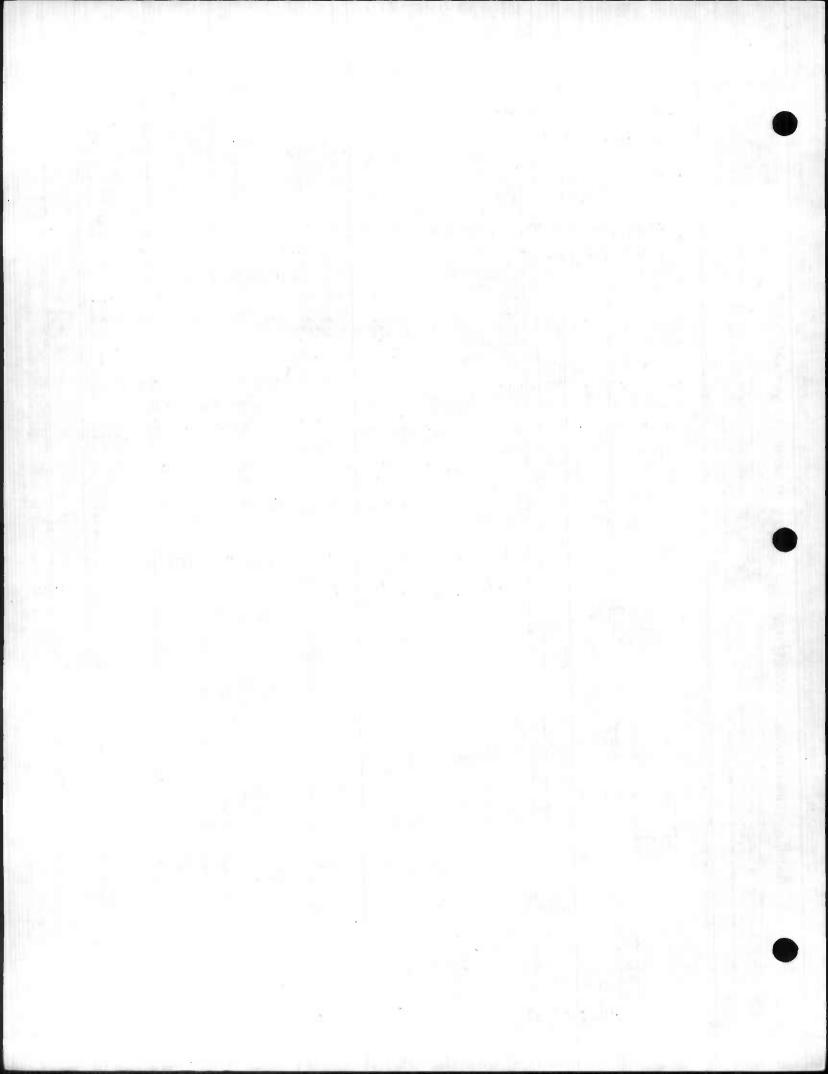
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		Subur	ban Hosp:	ital				Re	these	la	Me	ontgor	nerv
Funeral	5. Social Security			7. Age (In yr.	s. last birthde		der 1 Year	If Under 2		B. Date of Birth (Month, Day			lace (State or Foreig
Director	236-24-8	3722	1 X) M 2□ F	76	Yrs	Month	ns Days	Hours	Min.	(Month, Da)	16. 1922	North	n Carolina
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a or 28a-f show be notified at	10s. State	10b. County		10c. C	City, Town or	Location						10	Od. Inside City Limits
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age a	5	George	Guffey						(ola Han	npton		
1		Neme/Relationshi			19b. M	eiling Addre	ess (Street	t and Number			r, City or Town,	State, Zip	Code)
er tra	Frances	S. Guffy	/ Wife		220	13 T.O.	7e11	Street	Reth	nesda	Maryla	nd 201	817
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58 2										24a. Was	an autoney	24b Wa	ere autopsy findings
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rector, page 2 should	8									1 D Y	es 2 No	10	Yes 2□No
Ctor.		erred to medical						26. Place	of Death ((Check only o	ne)		
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era .			28a. Date of	of tnjury h, Day Year)	28b. Time		28c. Inju	ny et	28	d. Describe h	ow injury occur	rred	
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led in by the funer	4 ☐ Hornicide	-510111111	buildir	ng, etc. (Spec	cify)					City or Tow	m, State)		
completely filled in by the funeral	29a, Certifier	1 Certifying	Physician: To the	best of my kr	nowledge de	ath occurr	ed et the tie	ime, date end	d place an	id due to the	ause(s) and m	anner as et	ated.
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	30. Name and ad	s of person wi	ho completed caus		em 23a) (Typ	oe, Print)	111.		1.0	cheur c	1/115 1	10 2	2811
	1 6	DARRY	S TALE	SNICK	7	5454	wis	(MISHO)	Anc	CLICAL (and M	1 0	811
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Dominton	11	N 9 9 10	00 //1	merchan	7.	100	alla						



			Ce	rtificate o	f Death		Reg. No	o. 1	6	1944
	1. Decedent's Nama (First, Middle, Last)					2. Data of Month			Year	3. Tima of Death
hysician 'Medical	Mae Jeannette Gloti	feltv				JUNE	25,	"1999	roar	5:30 AM
xaminer	4a Facility Nama (If not institution, give stre				4b. City, Town	n, or Location of De	ath 4c	c. County o	of Death	
	RAVENWOOD LUTHERA	AN VILLAGE			HAGEI	RSTOWN		WASH	INGTO	ON
1	Social Security Number 6. Sex		s. last birthday)	If Under 1 Ya		Hrs. 8. Date of	Birth Year	,	9. Birthple	oca (State or Foreig
	577-34-0324 1 ¹	² ₩ F 78	Yrs.	Months Day	ys Hours	Min. 8. Date of (Month) May 9	, 192	21	Mary	land
	Usual Residence of Decedent									
	10a. Stata 10b. County	10c. 0	City, Town or Lo	cation					10	d. Inside City Limit
010	WV Berkeley	,	Fa	lling W	aters					1 ☐ Yas 2X N
Director	10e. Street and Number			11 ing W	9		10g. Cit	itizen of W	hat Countr	ry?
runeral L	211 Twin Falls Driv	re			25419			US	A	
	11. Marital Statue 12.	Was Decedent Ever in Armed Forces?	U,S. 13.	Was Decedent of	of Hispanic Origin	n? (Specify Yas or Puerto Rican, etc.)	No-		- Amarica	
	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Giva		1 ☐ Yes 2 🛣 N						
	3 ☐ Widowed 4 🎇 Divorced	Year or Datas:		الله عرب	o opeany.			Specity:	Wh	nite
	15. Decedent's Educati (Specify only highest grade of		16a. Dece	dent's Usual Occ	cupation ne during most o ired)	of working	16b. K	(ind of Bus	siness/Indu	ustry
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use ret	ired)					
	12			ustomer	Service				tel	
9	17. Father's Nama (First, Middle, Last)	c 1.				Nama (First, Mide				
2	George Samuel Glots	tetty			Hat	ttie Viol	a Low	wderm	ılk	
	19a. Informant's Name/Ralationship (Type,	Print)	19b. Meili	ng Addrass (Stre	et and Number	or Rural Route Nu	mber, City	or Town, 5	State, Zip (Code)
	Joy A. Haskiell/Ne:		P.O.	Box 686	, Fallin	ng Waters				
	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem		. Place of Dispo cemetery, crea	natory or other p	olace)	Date	20c. L	ocation - C	City or Tow	m, Stata
	4 Donation 5 Other (Specify)	The second second	tuooda	Com	Juno 20	1000	7	ani da	ant I	MD 21520
	21. Signature of Funesal Service Licensee	1	22	2. Nama and Add	drass of Fecility	1999 Newman F	unera	al Ho	mes,	P.A.
	De Sur Plus									
	23a. Part1. Enter the disease, or complicat shock, or beart lailura. List only one of		ath. Do not en	er tha moda of o	r St, Po	Box 275	y arrest.	antsy	ille	Approximate Interval Between
1	shock, orbant lailura. List only one of	ause on each line.								Interval Between Onset and Death
	Immediate Causa (Final	MIT	0 1	. 10			1 -1		i	170
	disease or condition resulting in death) a	Alterase	Lero 11	e Car	ajo va	scular	OUL	Stas	C . !	MINS.
6		() () () ()	(or as a consec	A A WILL					1	E MANITON O
CABILLING	b	CARDIA	(or as a consec		4/14.				1	5 MONTHS
	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury c	00010	(or as a consec	poerice orj.						
edical	Cause (Disease or injury that initiated events	Dinto	(or as a consec	wanna offi						
j	resulting in death) Last	Dua to	(Or as a consec	derica or).						
5	d									
	Date of the second seco		hat I at	4.1.1			2-14-4			AA
Physiciani	Part II. Other significant conditions contrib	uting to death but not re	esulting in the u	nderlying causa	given in Part I.					the cause of death
						1	☐ Yee 2	2∟ No	3 Prob	ably 4 Unknow
2						24a W	as an auto	opsy	24b. War	ra autopsy tindings
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0 00	25. Was case referred to medical axaminer?	oitel:			26. Placa o	f Death (Check on	ly one)			
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cel tilleation.	i dagraturar o [] i orioning	28a. Data of Injury (Month, Day Year)	28b. Time o Injury		njury at Vork?	28d. Descri	be how inju	ury occurre	ed	
	2 Accident investigation 3 Suicide 6 Could not be			M 1	☐ Yas 2 ☐ No					
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	√									
BOIDS	29a. Certifier Check only 2 Medicat Examiner	en: To the best of my kr	nowledge, deat	occurred at the	tima, data and p	place, and dua to t	ha causa(s	s) end man	nnar as sta	the cause(s)
	one)	end menner steted.				wa we trick this				
Σ	29b. Signature and little of certifier	1 1 1			ense number		29d. Da	ata signed	(Month, D	lay, Year)
	Mayer ,	May,		12	836 5	5	6	125	140	7
	30. Name and eddress of person who comp	leted cause of death (Ite	em 23a) (Type,					1		
	MANZAR JSI	TAF1 13	68 191	ILC ST	REE T	HACI	ERS7	1000	ai 2	1740.
te	31. Date liled (Month, Day, Year)	32. Registrar's Sign								
ar	JUN 2 9 1999	9 Bener	~ B.	doa	the					
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ORIGINAL



Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🕦 🔾 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey 1999 **Physician** Ikey W. Hurt 3:10 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Months Days 10XM 2□ F Hours Yrs 70 Director 400-32-7603 Nov. 18, 1928 Kentucky Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits show 1 ☐ Yes 2 1 No Directo notifie Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 11310 Hounds Way 20852 flerns 23a United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 X Yes 2 No
If Yes, Give
Year or Dates: Korea 1 Never Married 2 Married 'natural', or 1 Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) poemit. Pages 1 and 2 ahouid be filed wit. Department of Health and Mental Hygient important: if them 27 is marked other tha any injury or other traumatic event, that anos. Executive Vice President Printing Company 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumama) 88 John B. Hurt Lula Harrell 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 11310 Hounds Way, Rockville, Maryland 20852 Mary E. Hurt/Wife 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) June 19, 1999 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland Rödland Addres of Facility of Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 rd Funeral Service Licenses M00198 00 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or head feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finat disease or condition resulting in death) Metastatic Prostate Cancer Examine Due to (or as a consequence of): Examiner Pneumonia attending physician and for use as the burlei-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Sepsis Physician/Medical Due to (or es e consequence of): Renal Failure Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 3 Probably 4 ☑ Unknown Congestive Heart Failure 1 | Yes 2 | No by 24b. Wera autopsy findings available prior to Completed 24a. Wes en autopsy performed? Coronary Heart Disease completion of cause of death? page 2 Pathologic Fracture Right Femur 1 ☐ Yes 2 ☐ No cartificate Be 25. Was case referred to medical 26. Place of Deeth (Check only one) axaminer/ 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After i or Attending F attar deeth. 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurat Route Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours aft To the Funerel Di completaly filled in 10% Cartifying Physicians To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier c. On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of continu 29c. License number 29d. Date signed (Month, Day, Year) 6 t D38250 JUNE 22, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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Baltimore, Maryland

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6-16-99

DHMH 16 Rev 6/95

Michael R. Chardack, M.D.

JUN 23 1999

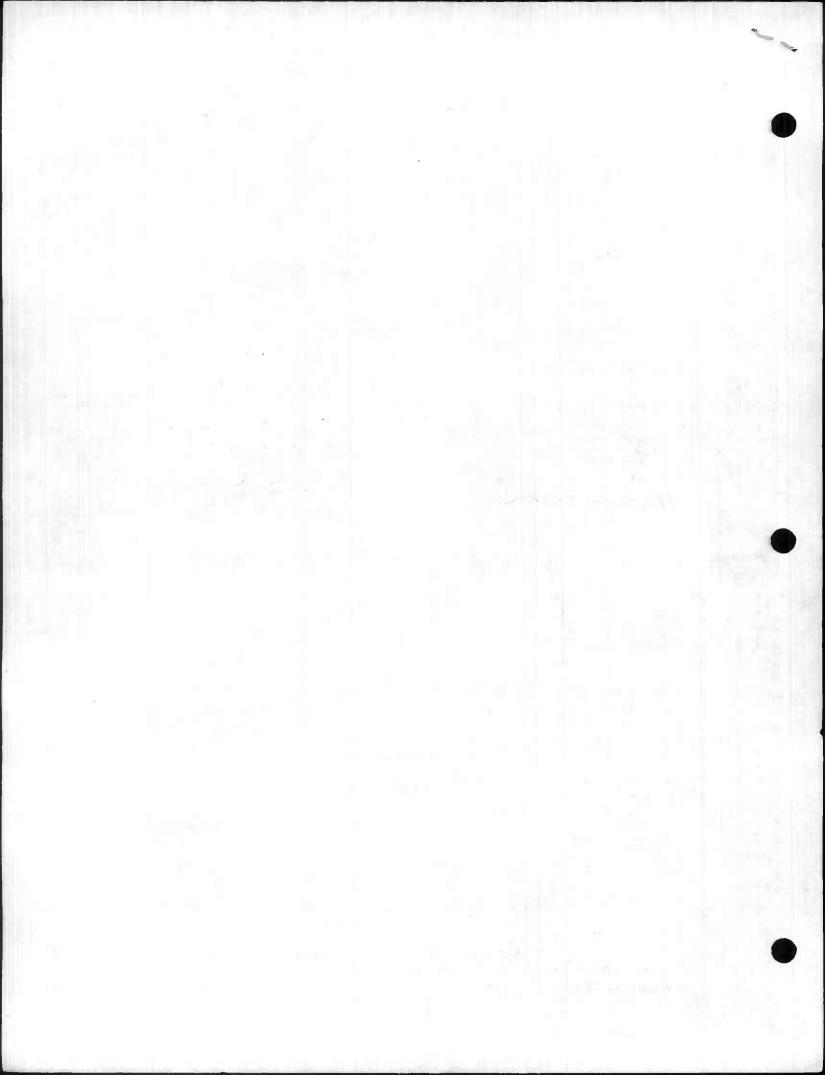
31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signeture

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6410 Rockledge Drive, #309 Bethesda, Maryland 20817



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Physician JUNE /Medical 4a Facility Name (If not institution, give street and nur 4b. City, Town, or Location of Death 4c. County of Death Examiner HUnder 24 Hrs. 8. Dete of Birth (Month, Dey, Year) August 20,1917 Pennsylvania AGNES BALTIMURE HUSATAZ If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 XF Days 81 160-16-6928 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 N Yes 2 No Directo Maryland Baltimore (City) 調 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? United States 8 21229 2441 Ashton Street 238 of America 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Rece - American Indian. 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, apecify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after Hygiene, ther then "natural", or the 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: ğ 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) pamit. Pages 1 and 2 should be filled will Department of Health and Mental Hygiens important: if item 27 is marked other the any injury or other treumatic event, the 1906. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumeme) George Robert Veatts Carrie Mae Markle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ruth Younkins - Daughter 2441 Ashton Avenue Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State Singers Glen, 1 Burial 2 Cremation 3 Removet from State 6/19/99 Singers Glen Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Virginia 22. Name and Address of Facility Lindsey Funeral Home, Inc. 21. Signature of Funeral Service Licensee #M00690 SouthMain Street, Harrisonburg, Virginia 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset end Death Physician /Medical Immediata Cause (Final HEART PAILURE CONGESTIVE disease or condition resulting in death) Examine Physician/Medical Examinar BETES m5261 attending physician and for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): BESITY Box 68760, Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 JUnknown Elmon A þ 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed HYPERTENSION Dage 2 1 Yes 2 No 1 Yas 2 No 8 25. Was case referred to medical 26. Place of Death (Check only one) To. Hospital: 1 19 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. tnjury et Work? Certification: 1 CNaturat 5 Pending investigation efter death. 1 ☐ Yes 2 ☐ No 2 Accident 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 6 4 ☐ Homicide filled in ? 6 To the Hospital o within 24 hours of To the Funeral Di completely filled is 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 20b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 kom MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar Jackson, M.D.

31. Date filed (Month, Day, Year)
JUN 23 1999

32. Registrar's Signature

900 Caton Avenue, Baltimore, Maryland

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Month June 7, 1999 **Physician** Mary M. Harley 7:00 A.M. /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth Seat Pleasant Prince George's **Examiner** 303 70th Street | Months | Deys | Hours | Min. | Min. | December 15, 1924 | Mary land 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** 1□M 2⊠F 74 Yrs. 213-84-3185 Director Usuel Residence of Decedent the Merylend show 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Seat Pleasant the Medical Examiner must be notified at Prince George's Maryland ¥XYes 2 No Director 288-1 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code ò 20743 303 70th Street 230 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Detes: items ! 11. Meritei Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. e filed within 72 hours efter at Hygiene. other than "natural", or ite 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 Specify: Black 1 ☐ Yes 2 🕅 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 7th grade College (1-4or 5+) N/A Unemployed permit. Pages 1 and 2 should be file Deperment of Health and Mertel Hyg Important: If Item 27 ie marked othe any injury or other treumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame)
Margaret Newman 17. Fether's Neme (First, Middle, Last) Be George Harley 19e. Informent's Neme/Reletionship (Type, Print)
Mrs. Gloria O. Newman (Sister) 19b. Mailing Address (Street and Number of Fural Boyte Number City of Town 28410/2610 Code) 20b. Plece of Disposition (Name of cemetery, cremetory or other place)
Resurrection Cemetery 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1XXBuriel 2 ☐ Cremetion 3 ☐ Removel from Stete 6/11/99 Clinton, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fedility
Rollins Funeral Home, Inc. 21. Signeture of Funerel Service Licenses 4339 Hunt Place, N.E. Washington, D.C. 23e. Pert1. Enter the sees for compleshock, or heert ailure List only or Approximate Interval Between Onset and Death pheations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, one cause on each line. **Physician** Immediete Ceuse (Final diseese or condition resulting in deeth) /Medical Cardio pul monary Examiner Examiner Due to (or es e consequence of): physicien end is the burief-transit that the death certificete be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Lest Box 68760. At nea Dsa Due o (or es e consequence of) Physician/Medical for use es 98 P.O. detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Records. Completed by been si 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? page 2 1 ☐ Yes 2 ☐ No 1 □ Yes 2 □ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certification by the funeral director, 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: Certification: To Other: 4 Nursing Home 5 N Residence 8 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homlcide e Funeral compietely filled edical 29e. Certifier 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. To the within 2 29b. Signeture end title of certifier > 29c. License number 29d. Dete signed (Month, Dey, Year) D09162 June 22, 1999 Nagemeny pleted cause of death (Hem 23e) (Type Print) 6196 Oxon Hill Road Oxon Hill, Maryland Suite 250 Jafar Nazemian, M.D. 31. Dete filed (Month, Dey, Year) Registrer's-Signeture State JUN 2 3 1999 Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🔍 🔾 Certificate of Death 1. Decedent's Name /First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dav Yee Physician KATHERINE HARGISS JUNE 14 1999 8:02 PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner CLINTON SOUTHERN MARYLAND HOSPITAL PRINCE GEORGES If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6 Sex Year) **Funeral** Min. Months Hours 1□ M 250 F Davs 78 Director 579-18-0304 MARCH 30, 1921 PENNSYLVANIA Usual Residence of Deceden the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo MARYLAND CHARLES LA PLATA 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 HICKORY LANE 20646 UNITED STATES Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1□ Yes 2♥ No Baltimore, Maryland 21215-0020 Specify Specify: WHITE 2 3 Widowed 4 Divorced Year or Detes: Completed Decedant's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 PERSONNEL AIDE STATE GOVERNMENT marked other 17 Fether's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental h Pages 1 and 2 should be JOHN POLIS NELLIE BALBOA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Ralationship (Type, Print) of Health a Hern 27 ls JOHN HARGISS, SON 13358 GOLF CREST CIRCLE, TAMPA, FLORIDA 33624 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 10 21 1 ☐ Buriel 2X Cremation 3 ☐ Removal from State 8 Department 2 Important: If 4 □ Donation 5 □ Other (Specify) 6-18-99 FORT LINCOLN CREMATORY BRENTWOOD, MARYLAND 22, Name end Address of Fecility 21. Signature & Fineral Service Licensee FORT LINCOLN FUNERAL HOME INC. M00907 3401 BLADENSBURG RD, BRENTWOOD MARYLAND 20722 23a. P. n.1. Enter the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory arrest, hock, or heer failure. List only one cause on each line. Approximate Intarval Batween Onset end Deeth **Physician** /Medicai Immediate Causa (Final PERITONITIS disease or condition rasulting in death) **Examiner** Due to (or es a consequence of): Examiner RUPTURED ABDOMINAL VISCES 1 week physician end the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated evants resulting in death) Last Due to (or es a consequença of): requires that the deeth certificate be exec METASTATIC INTRA-ABDOMINAL MALIGNANCY P.O. Box 68760. Physician/Medical Due to (or as a consequence of): 88 US6 ŏ Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 1 be detacl 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Wera eutopsy findings available prior to completion of cause of death? 24e. Was an autopsy Completed peen we. page 2 has 1 Yes 2 No 1 Yes 2 No certificate Hospital or Attending Physician: 25. Was case referred to medical Be 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 1 Natural iniun 5 Pending after deeth. 1 Yes investigation 2 Accident within 24 hours after dee To the Funeral Director completaly filled in by th 6 Could not be datarmined 3 Suicide 28a. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1/2 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, data and place, and dua to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, date and place, and dua to the causa(s) 29a. Certifier edical (Check only one) and manner stated. To the 29c. License number 29d. Date signed (Month. Bay Year) 29b. Signature at title of certifie 30. Name and addrass of person who complated cause of death (Item 23e) (Type, Print) Waldorf 11345 Pembroom 5 Howe eme 32. Registrar's Signature

Registrar **DHMH 16 Rev 6/95**

State

31. Dete filed (Month, Day, Year)

JUN 2 3 1999

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** HENNEBERGER M. 5:30Am 06 20 /Medical 4e. Facility Neme (If not institution, give streat end number) 4b. City, Town, or Location of Deeth 49. Facility Name (IT TOL ITSIMULION), S. CONTROLL SACILITY Number 6. Sex _ 7. Age (In yrs. last birthday) If Under 1 Year Months Deys Examiner 4c. County of Deeth PRINCE GEORGES HCheville if Undar 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Dey Funerai 9. Birthpiece (Steta or Foreign Hours Min 1907 Washington, DC 579-09-0619 91 Yrs. Director June Usuel Residence of Decedant death with the Maryland 10e State 10b. County 10c. City, Town or Location 28a-f show 10d. inside City Limits must be notified at Director 1 ☐ Yas 2 ☐ No Maryland Anne Arundel Sherwood Forest 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ŏ 666 Maid Marion 21405 items 23a U.S.A. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ② No if Yes, Give Yeer or Detas: 11 Marital Status Wes Decedent of Hispenic Orlgin? (Specify Yes or No If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - American Indian, Black, Whita, etc. filed within 72 hours after 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 ò 1 ☐ Yes 2 No Specify: by Specify: White 3 Widowed 4 □ Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decadent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementery/Secondery (0-12) School Teacher Public Schools other ment of Health and Mental H, nt: if item 27 is marked A 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Peges 1 and 2 should be Augustus R. Glasgow Lena Josephine Scheuch 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mary H. Hall - Daughter 666 Maid Marion, Sherwood Forest, MD 21405 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stele 1 N Burlei 2 □ Cremetion 3 □ Removel from State permit. Pege Department of Important: If eny injury or 4 ☐ Donetion 5 ☐ Othar (Specify) Metropolitan Crematory 06/23/99 Alexandria, Virginia 21. Signature of Funesal 22. Name and Addrass of Facility
Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 our to not entar the mode of dying, such as cardiec or respiretory errest, 23e. Pert1. Enter the displan, or shock, or heart feilure. List complications that caused the death only one cause on each line. **Physician** /Medical immediate Cause (Final PULMONARY EDEMA 48/tours diseese or condition resulting in deeth) **Examiner** Due to (or es e consequenca of): Physician/Medical Examiner HYPO ALBUMINEMIA 3 MONDIS sician and buriel-transit or Attending Physician: The law requires that the death certificeta be executed Sequentielly list conditions, if eny, leeding to immediate cause. Entar Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or as a consequenca of): P.O. Box 68760. RENAL NEDPLASM 6 MONTHS the Due to (or es e consequence of): Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. igned by the a 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HUPBRTBNSION þ Records, Completed 24b. Were eutopsy findings aveilebie prior to completion of cause of death? 24a. Was an eutopsy performed? RENAL INSUFFICIENCY BRAIN certificata 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital DEMENTA 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpalient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Vursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 28a. Dete of injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Neturel 5 Pending investigation daath. ours efter daath. erai Director: A filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Pleca of injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete) 4 Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end dua to the cause(s) end manner es steted. 29e. Certifier Medical pletaly (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deelh occurred at the time, date and place, and due to the cause(s) end menner stated. To the Vithin 2 To the I 29b. Signatura and titla of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) D46834 30. Name and eddress of person who completed cause of death (item 23a) (Type, Print)

State Registrar

31. Dete filed (Month, Dey, Year) JUN 2 3 1999



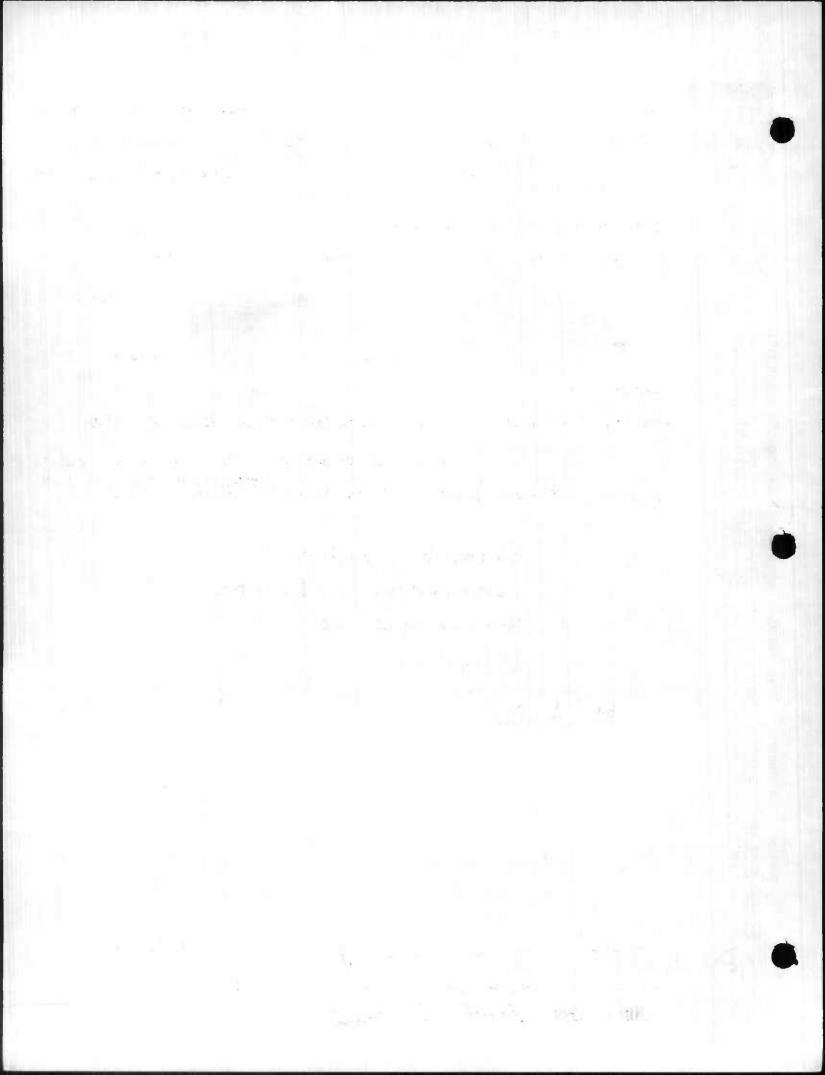
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Richard 19 1999 June 8:50 a.m. /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) **Examiner** Southern Maryland Hospital Prince George's Clinton If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** 1₩ M 2□F Months Deys Yrs **Director** 217-60-8292 48 May 27, 1951 Arlington, VA Usual Residence of Decedent the Maryland r 28a-f show 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1⊠ Yes 2□ No Director Maryland Prince George's Temple Hills 10f. Zip Code 10g. Citizen of Whet Country? item 27 is marked other than "naturel", or items 23a or other traumstic event, the Modical Examiner must be a permit. Peges 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23s any injury or other traumatic event, the Medical Examinet must page. 3405 Leslie Avenue 20748 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien. 11. Maritel Status Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 12th Manager Private 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumeme) Stephen J. Havas Louise Kyler 19e. Informant's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Gerald O. Rima/friend 3405 Leslie Avenue Temple Hills, MD 20b. Place of Disposition (Name of cemetery, crametory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 6 - 23Alexandria, Virginia 22. Name and Address of Fecility MARSHALL'S FUNERAL HOME OF MD 21. Signeture of Funerel Service Licensee melly chaises 10mic 4308 Suitland Road Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediate Ceuse (Final diseesa or condition rasulting in death) /Medical Examiner Examiner ettending physician and for use es the bunel-transit Sequentielly list conditions, if eny, leeding to immediata causa. Entar Underlying Ceuse (Disaasa or injury thet Initiated evants resulting in death) Lest Dua to (or as e consequanca of) per cal cencia P.O. Box 68760, the death certificate be Physician/Medical Due to (or as a consaquanca of): 80 23b. Did tobacco use contributa to the cause of deeth? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably Unknown Division of Vital Records, þ 24b. Were autopsy findings aveilable prior to Completed 24e. Was en autopsy performed? completion of cause of death? page 2 certificate has 2/ No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No P 3□ DOA 1 ☑ Inpatient 2 ☐ ER/Outpetient After this funeral 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dev Year) Certification: 5 Pending invastigation 1 DNetural 1 Yes 2 No 24 hours after death. 2 Accidant 6 Could not be detarmined 3 Suicide Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) filled in by 4 ☐ Homicide Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medicai Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, daeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only To the within 2. 29b. Signature and little of 29d. Dete signed (Month. Dev. Year) 29c. License number 1)005 15 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Dr. Z. Ansari Clinton, MD 20735 7503 Surratts Road 31. Dete filed (Month, Dey, Year) 22. Registrer's Signeture State JUN 2 4 1999 Registrar



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State of Maryland / Department of Health and Mental Hygiene 99 2 | 55 |

				Certif	icate of i	Death			Reg. No.		
nysician	Decedent's Name (First, Middle			11	-1			2. Date of D	eath _Dey	Year 3	. Time of Death
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eral ctor	5. Social Security Number 238–72–1520	6. Sex 7. A 1 ☑ M 2 □ F	ige (In yrs. last birt) 55 Y		Under 1 Year onths Days	Hours Hours	24 Hrs. Min.	8. Dete of Bi (Month, D Novembe	rth ay, Year) r 29,1943	9. Birthplace Country) North	(State or Foreign Carolina
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0 8	Sidney B. Hous	ton, Sr.				Ali	ice N	IcConau	ghey		
-	19a. Informant's Neme/Relationsh	nip (Type, Print)	19b.	Meiling A	ddress (Street	and Numb	er or Run	al Route Numi	per, City or Town	, State, Zip Co	de)
	Nancy S. Houst	on/Wife	860)3 Bo	tlev Dr	cive.	Ft.	Washir	gton, M	larvland	7 20744
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Certi	4 Homicide detarmin	ned 200, Place of It	njury - At homa, fan tc. <i>(Specify)</i>	n, street,	rectory, office				(Street end Num own, State)	ver or Hurel Ad	oute rumber,
edical	29e. Certifier (Check only one) Certifying	Physician: To the best examiner: On the basis and manner s	of examination and	death occ or investi	curred at the tin gation, in my o	na, data an pinion, daa	nd place, ath occurr	end dua to the red at tha tima	causa(s) end m , data and place	annar es state , and dua to the	d. a cause(s)
Σ	29b. Signature and title of certifier				29c. Licens					ed (Month, Dey	
	12	Sid			011	53	65		6-	22 -	-99
	30. Name and address of person w	who completed cause of	death (Item 23a) (1		1)				D. (I		

DHMH 16 Rev 6/95

Registrar

JUN 2 4 1999

ALLEN W. HARRISON

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Division	Per en	Certification:	27. Manner of Death A Naturei 2 Naturei 2 Naturei	5 Pending investigation		y Year)		jury	М		rk? Yes 2□No					
	는 및 마		3 ☐ Suicide 4 ☐ Homicide	determined	28e. Piece of Injuding, et	ury - At h c. <i>(Speci</i>	ome, fer	m, stree	t, fectory	, office		28f. Location (S City or Town	treet end Numi n, Stete)	per or Rural	Route I	vumber,
	Hospital or 24 hours efter Funeral Dir letely filled in	dicai	29a. Certifier (Check only one)	Certifying Phy Medical Exam	rsician: To the best Iner: On the basis o end menner st	exemine	owledge, etion end	deeth o	ccurred a stigetion,	it the ti	me, date end place opinion, deeth occu	, and due to the c rred et the time, d	euse(s) and m late and plece,	enner es sta and due to	ated. the ceu	se(s)

State Registrar

KRISHAN M. MATHUR MD CAMBRIDGE PROFESSIONAL CENTER SUITE 102 WALDORF, MD 20602

31. Dete filed (Month, Day, Year) 32. Registrer's Signature

29b. Signeture end title of certifier

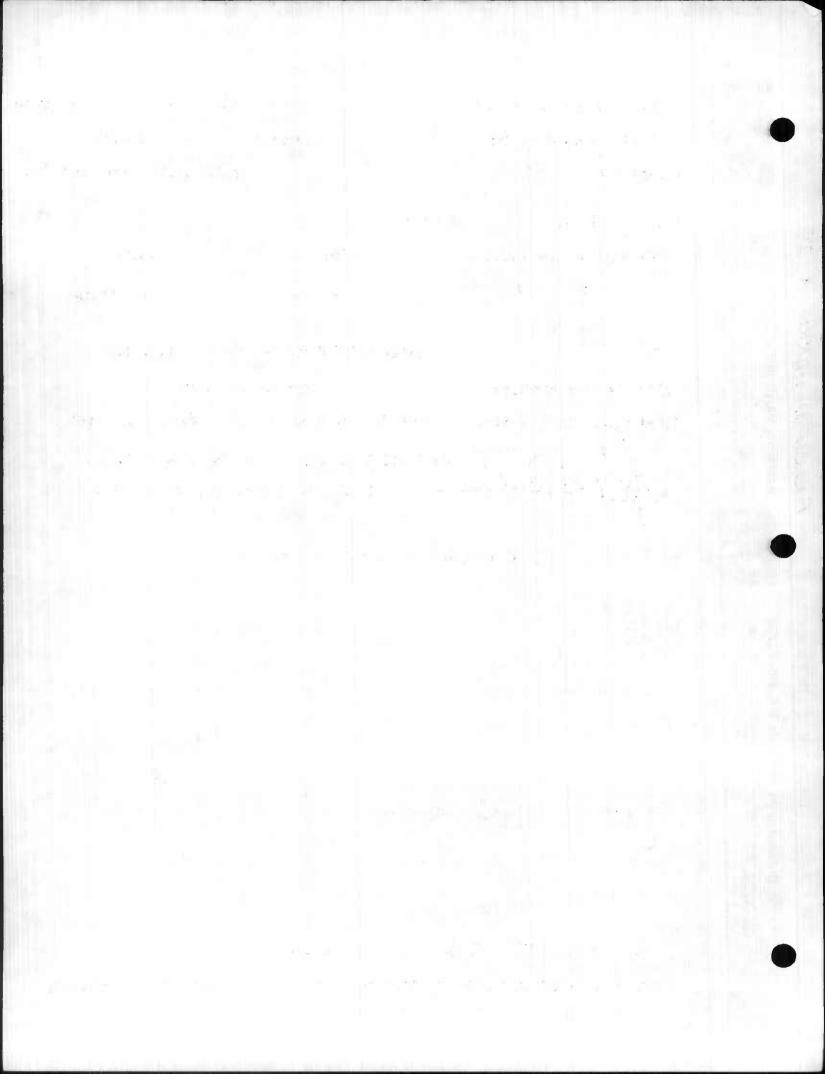
JUN 29 1999

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D-28352

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🥞 🖰

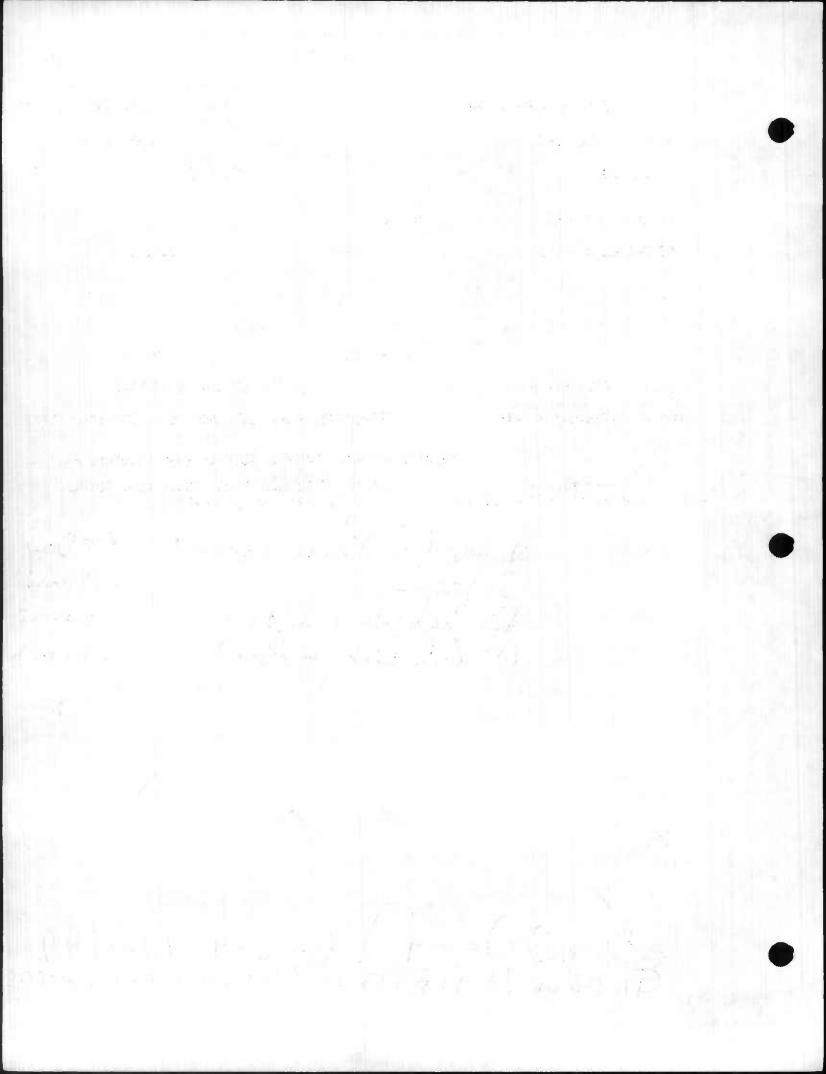
Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** 27, ELIZABETH BROOKMER HOGGE 1999 JUNE 12:03 AM /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not Institution, give street and number) 4c. County of Death Examiner GENESIS ELDER CARE LA PLATA CHARLES If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Days 1□M 2♥F Yrs. 228-22-7985 88 Director DECEMBER 16, 1910 VIRGINIA Usual Residence of Deceden the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahov traumatic event, the Medical Examination must be notified at 28a-f ahow 1X Yes 2 □ No MARYLAND CHARLES Director LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with ONE MAGNOLIA DRIVE 20646 U.S.A. Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Deles: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Stetus Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify Specify: WHITE à 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade com 16a. Decedent's Usual Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: If fam 27 is marked other than * any injury or other tearmatic event, Interland Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father'a Name (First, Middle, Last) WILLIAM HEALY STIFF MARY BROOKMER QUESSENBURY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARIE CATTERTON/DAUGHTER 734 FARMINGTON ROAD WEST, ACCOKEEK, MARYLAND 20607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Name Burial 2 Cremation 3 Removal from State TRINITY MEMORIAL GARDENS JULY 1, 1999 WALDORF, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Survivor Licensee 22. Name and Address of Facility
THE HUNTT FUNERAL HOME, INC., JOHN P. MUI164 WALDORF, MARYLAND 20604-01 as that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest as a neach line. KNISLEY 20604-0156 23a. Part1. Enter the disease, or complicate ahock, or heart failure. List only one complicate and the complex of the complex Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting In death) Last and the attending physician hed for use as the buna Physician/Medical Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yee 2 No 3 Probably W Unknown p Division of Vital Records, The law requires 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy periormed? peed has this cartificata 1 ☐ Yes 2 ☐ No Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Magher of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 28b. Time of Natural After 5 Pending 1 Yes Investigation Hospital or Attendi 24 hours after death Funeral Director: A death. Ccident filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and or myestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month 29b. Signature and title of certifier 25c. License numbe 30. N 31. Date fil 32. Registrar's Signature

State Registrar

29

1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

					Ce	rtificate of	Death		g. No.	, 6	1554
		Decedent's Name (First, Middle,	Last)					2. Date of Deat			3. Time of Death
Physician /Medical	ı	JOSEPH FRANCIS	HARVEY					JUNE 2	3, 1999	Year	1036 AM
Examiner		Facility Name (If not institution, g PRINCE GEORGES			?		4b. City, Town, or I		4c. County PRINC		ORGES
Funeral Director	0	91-34-9636	.Sex. 7. /	Age (In yrs. 56	last birthday Yrs.	If Under 1 Yea Months Day		8. Dete of Birth (Month, Day, NOV • 4,	1942	9. Birthp Cour MARY	elece (State or Fore
1		sual Residence of Decedent Da. Stete 10b. County		10c. Ci	ity, Town or L	ocation				1	0d. Inside City Lim
of a Po			na								Yes 201
23e or 28e-f show unit be notified at ral Director	10	IARYLAND CHARL De. Street and Number	ES	HUG	HESVII	10f. Zip Code		10	Og. Citizen of V	What Cour	ntrv?
2 0	3	3515 SLATER DRIV	E / ROUTE	5 BOX	291	2063	37		UNITED		
r ttems 23a directment	11	I. Merital Stetus	12. Was Deceder	nt Ever in U				pecify Yes or No-	14. Race	e - Americ	an Indian,
, A		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force	s? ⊈No		If Yes, apecify Cu 1 ☐ Yes 2 No.	Hispanic Origin? (Si ban, Mexican, Puerli Specify:	Rican, etc.)	Specify	k, White, BLA	
"natural", rdra Ex		15. Decedent's	Education		16a. Dece	dent's Usuel Occ	upation		16b. Kind of Bu	usiness/In	dustry
1 2 2	9	(Specify only highest g Elementery/Secondery (0-12) OTH GRADE	College (1-40	or 5+)		ARMER	e during most of wor ed)	king	FARMIN	NG	
th and Mental Hygiene. 7 is marked other than traumatic event, the Me	17	7. Fether's Name (First, Middle, La. JOSEPH COLE	st)					ne (First, Middle, M IIE HARVE		ie)	
Health and I		9a. Informent's Neme/Reletionship BETTY ANN HARVEY					PLACE, WAI				
# 0	20	Da. Method of Disposition 1 Burlel 2 Cremation 3 4 Donation 5 Other (Special Control of			cemetery, cre	osition (Name of matory or other pi MEMORIAL	GARDENS		20c. Location - WALDORI		
Department of Important; If it any injury or page.	2	Signature of Funeral Service Lice	ensee Full June TON JOHNSO	beson		2. Name end Add HORNTON	ress of Fecility FUNERAL HO	ME, P.A.	N LIEND	MD	20640
	2	3a. Part1. Enter the disease, or co shock, or heert tailure. List on	mplicetions that caus	ed the deet	th. Do not en	ter the mode of d	ring, such es cardiac	or respiratory erre	est,	, PID	Approximate
nysician Medical kaminer	In di	nmediete Ceuse (Finel iseese or condition suiting in deeth)	Ц	eltip	le le					1	Onset end Deeth
in and ial-transit Examiner					or es a conse	quence of):	P.				
sician a burial-	Sit CiC	equentially list conditions, sny, leeding to immediate ause. Enter Underlying ause (Disease or Injury set hitistated events	b	Due to (d	or es e conse	quence of):					
physicia s the bur edicai	C th	equentially list conditions, sny, leeding to immediate ause. Enter Underlying ause (Diseese or Injury let initiated events suiting in death) Last	c	Due to (d		quence of):					
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igned by the attending physicial be detached for use as the but by Physician/Medical	Pe	est illimeted events switting in death) Last	c d contributing to death	Due to (d	or es e conse	quence of):	iven in Pert I.		autopsy	3 Pro	bably 4 Junkn ere autopsy finding allable prior to mpletion of cause
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certificate has been signed by the attending physicia irector, page 2 should be detached for use as the but Be Completed by Physician/Medical	C the re	er life de events suiting in death) Last suiting in death) Last ert II. Other significant conditions in the conditions i	Hospitel:	Due to (c	or es a conse	quence of): quence of): underlying cause of	26. Place of Dec	24a. Was ai perform	n autopsy ned?	3 Pro	ere autopsy finding aliable prior to mpletion of cause death? Tes 2 No
or death. ector: After this certificate has been signed by the attending physicial by the funeral director, page 2 should be detached for use as the but liftcation: To Be Completed by Physician/Medical	Per Per 255	er lifered events suiting in death) Last suiting in death) Last er il. Other significant conditions of il. Other significant conditions is. Wes case referred to medical	Hospitel: 1 □ Inpa 28a. Dete of In (Month, L 28e. Plece of In 28e. Plece of In	Due to (continue t	or es a consecutive de la consecutiva della cons	quence of): quence of): underlying cause of nt 3 DOA C	26. Place of Dee hither: 4 ☐ Nursing H ury et ork? ☐ Yes 2 No	24a. Was air perform	n autopsy ned? s 2 No s 2 No e) nce 6 Other introduces	3 Pro	bably 4 Unkn ere autopsy finding aliable prior to mpletion of cause death? Ores 2 No No Unkn
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Registrar

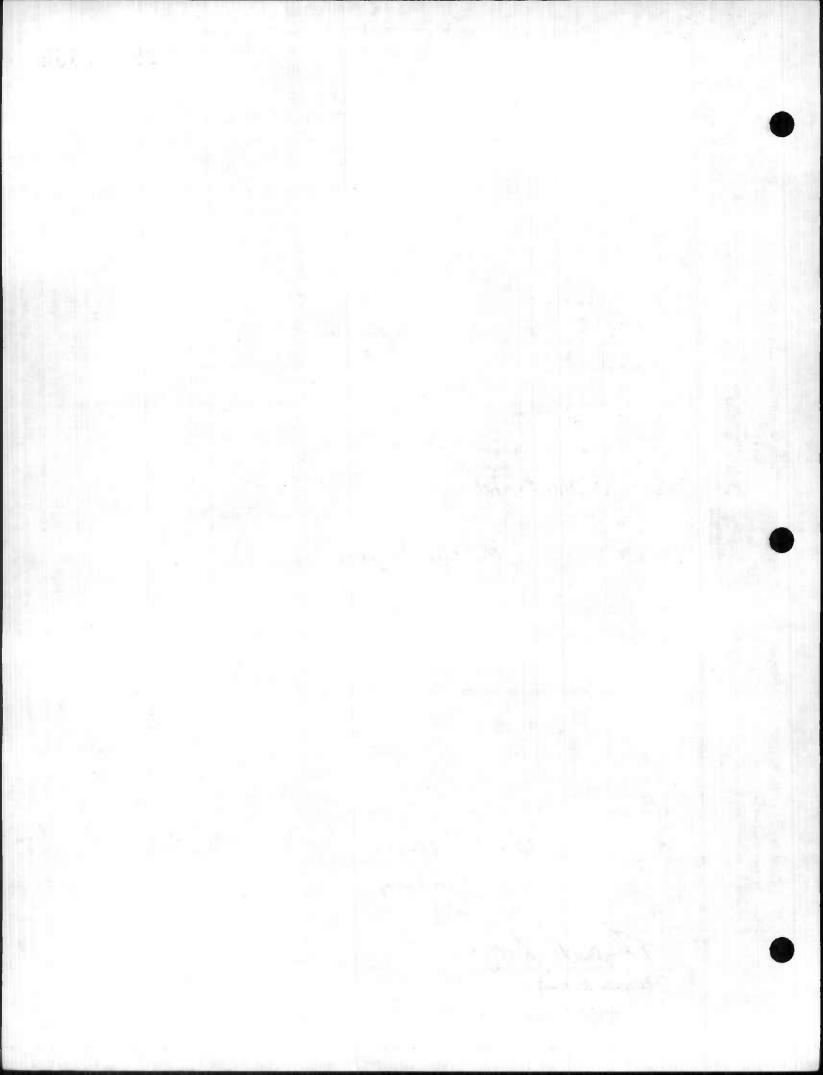
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31. Dete filed (Month, Dey, Year)

JUN 28 1999

Sporks

32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene

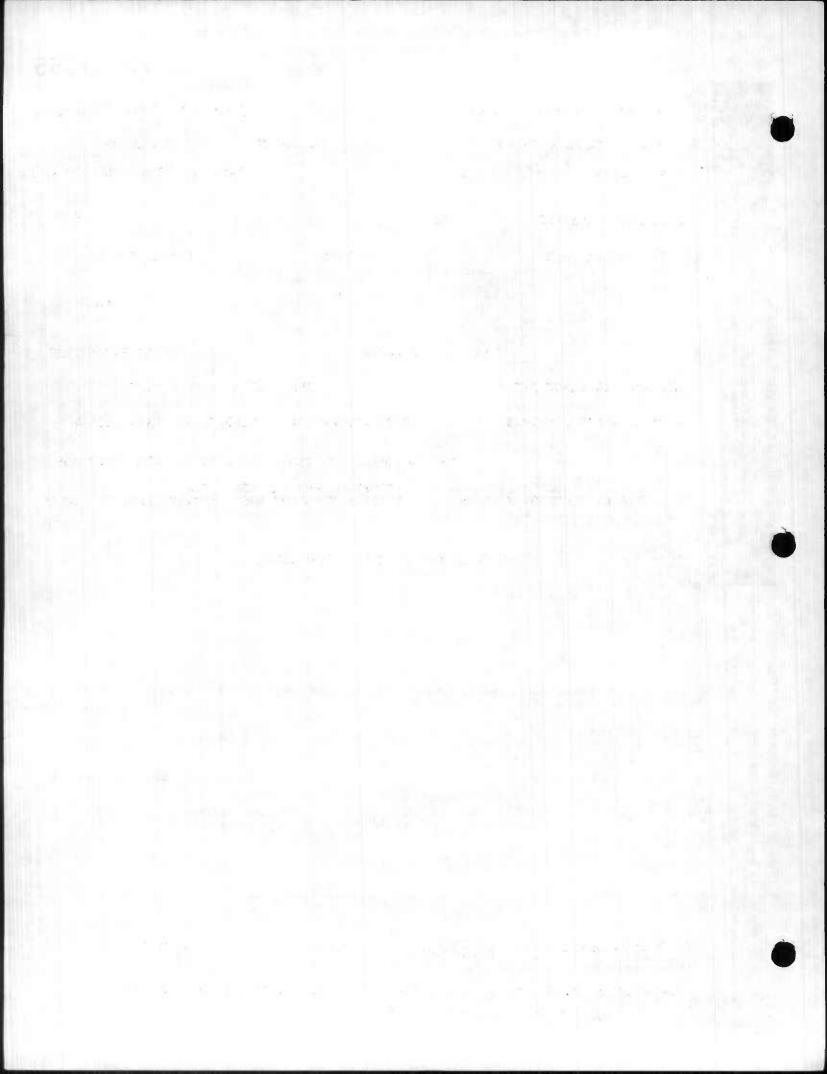
Certificate of Death 3. Time of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Dey **Physician** 1999 2:55PM BRYANT ANTRON HTCKS JUNE 23 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner 10578 BUTLER ROAD NEWBURG r if Under 24 Hrs CHARLES If Under 1 Year 8. Dete of Birth (Month, Dey, Year) Birthpiece (Stete or Foreign Country) 5. Social Security Number 6. Sex 7. Age (fn yrs. lest birthdey) **Funeral** Months Deys Hours Min XIX M 2 F Yrs. 23 18, 1976 WASHINGTON, D.C Director 218-17-4595 Usuel Residence of Decedent the Meryland 10a. Stete 10c. City, Town or Location 10d. inside City Limits 10b. County r than "natural", or frame 23s or 28s-f show the Medical Examiner must be notified at 1X Yes 2 □ No Directo MARYLAND CHARLES NEWBURG 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code with 1 10578 BUTLER ROAD Funeral 20664 UNITED STATES death 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American indien, Bleck, White, etc. 11. Maritel Status pemit. Pages 1 and 2 should be filed within 72 hours after Depermant of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or itel any injury or other traumetic event, the Medical Examinations. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 1 Never Married 2 ☐ Married Maryland 21215-0020 1 Yes 2 No Specify. Specify: þ **BLACK** 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind ot Business/Industry College (1-4or 5+) 1 YEAR Elementery/Secondery (0-12) FLAGGER PUBLIC FACILITIES 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) MICHAEL LINDBERGH HICKS JUDY MARIE JUPITER HICKS 19a. intorment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) JUDY M. HICKS / MOTHER 10578 BUTLER ROAD NEWBURG, MARYLAND 20b. Piece of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removei from Stete 4 ☐ Donetion 5 ☐ Other (Specify) SHILOH CHURCH CEMETERY 6/28/99 NEWBURG, MARYLAND 21. Signeture of Funeral Service Licensee 22. Neme end Address of Fecility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD INDIAN HEAD, MD Lydial. knoon LYDIA C. THORNTON JOHNSON 20640 Approximete Interval Between Onset end Deeth 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tellure. List only one cause on each line. **Physician** Immediate Ceuse (Finei diseese or condition resulting in deeth) /Medical ACUTE LYMPHOBLASTIC LEUKEMIA Examiner Due to (or es e consequence of): Examiner attanding physician and for use as the bunal-transit requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence ot) use as t ed by the a P.O. Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? signed by ti 1 Yes 2 No 3 Probably 4 Unknown þ 24e. Wes en eutopsy performed? 24b. Were autopsy tindings aveileble prior to Completed peen completion of cause of death? The law has 1 ☐ Yes XXNo certificate Division of Vital or Attending Physician: 25. Wes case reterred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home ** Nursing Home 6 Other (Specify) Certification: To 1 ☐ Yes XX No After this funeral 28d. Describe how injury occurred 27. Manner of Deeth 28a. Dete of tnjury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? Naturel 2 Accident 5 Pending 1 Yes 2 No death. investigation s efter death 6 Could not be 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury · At home, term, street, tactory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours e To the Funeral E Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated edical 29a. Certifier npletaly 1 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29b. Signature end title ot cartitier 29c. License number 29d. Dete signed (Month, Dey, Year) D28352 JUNE 23, 1999 30. Neme and eddress of person who completed cause ot deeth (Item 23e) (Type, Print)

BOX 1703, LA PLATA, M.D.

State Registrar KRISHAN MATHUR, M.D. P.O. 31. Date filed (Month, Day, Year) 32. Registrer's Signeture

Orpera

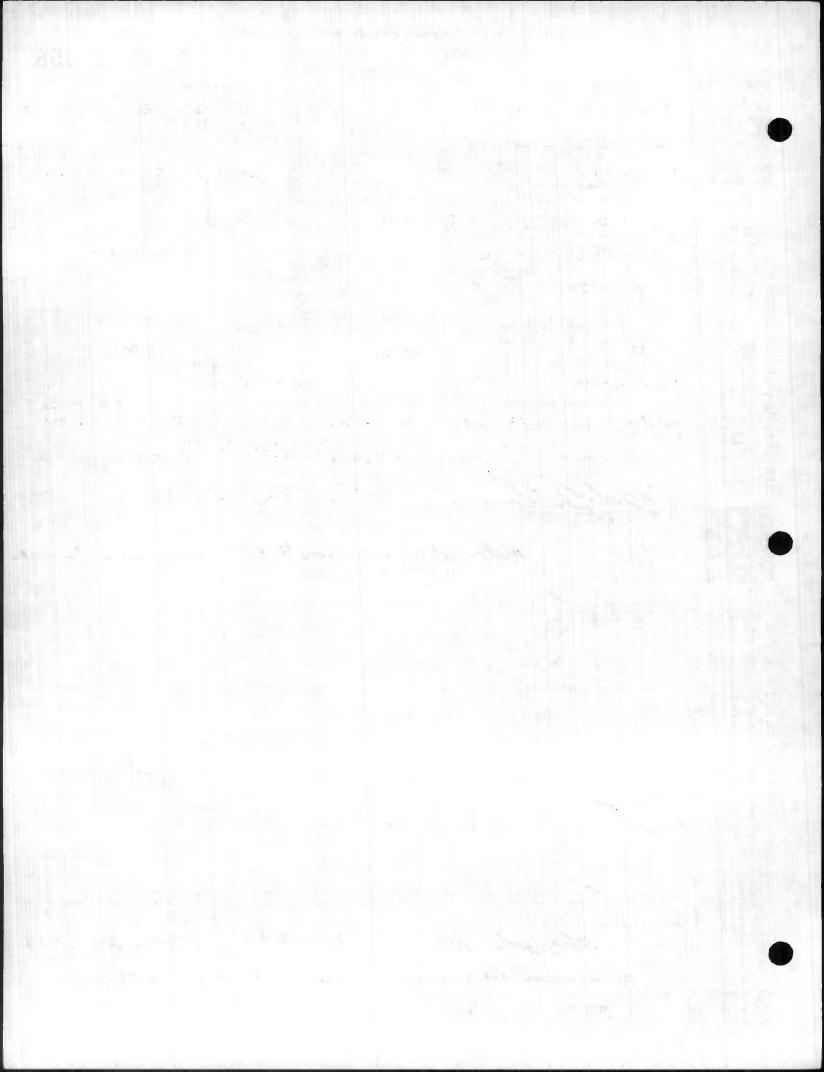
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State of Maryland / Department of Health and Mental Hygiene 99 21556

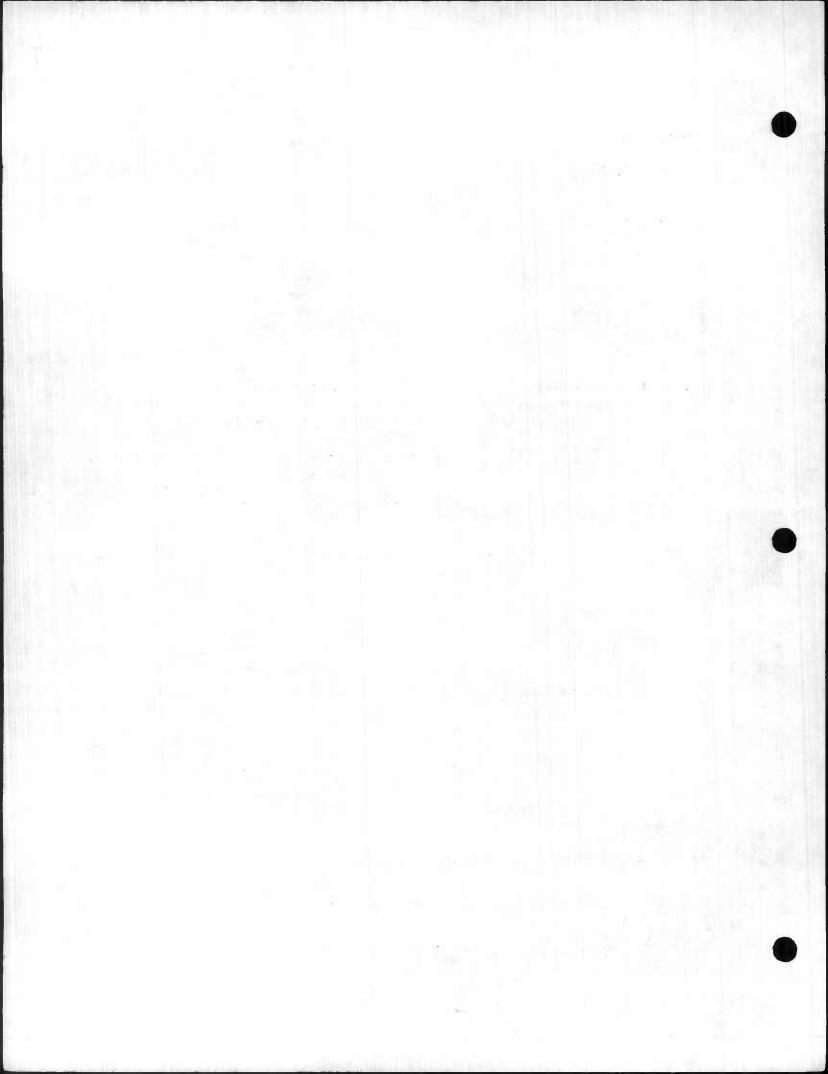
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mar 373.000	1. Decedent's	Name (First, Middle, La	est)							2. Dete of Dee Month	eth Day	Year	3. Time of Deal
Physician /Medical	Eliza	beth Casele	Humphrey							June 24			3:45 a
Examiner	4a Fecility Na	me (If not Institution, given	ve street and number	r)				4b. City, Tow	vn, or Lo	cation of Death	4c. County	of Death	
	4695	Smallwood C	Church Roa	d				Indian	Hea	.d	Char	Les	
Funeral	5. Sociel Secu	urity Number 6.	Sex 7. A		last birthday)) If Und Month	der 1 Year		24 Hrs. Min.	8. Date of Birtl (Month, De)	Year)	9. Birthp	lace (State or For
Director	185-20	-4791	1□M X0XF	72	Yrs.	IVIOLITI	Days	Hours		gust 22	, 1926	Penns	sylvania
0		nce of Decedent											
r 28a-f show	10a. State	10b. County		10c. Cit	y, Town or Lo	ocation						1	0d. Inalde City Lie
Ct His o	Marylan	d Charles		Ind	lian He	ead							1 Yes 2)
or 28s-4 s. be notified	10e. Street an	nd Number				10f. Z	Zip Code				10g. Citizen of	What Coun	itry?
ms 234 or	4695 S	mallwood Ch	nurch Road			2	20640			J	Jnited S	States	S
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or the		Married 20 Married	1 ☐ Yes 2 📉				2XXV0		, , , , , , , , , , , , , , , , , , , ,	noun, oto.,			
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and Mental Hygiene. marked other than metic avant, the		lame (First, Middle, Last	1)					18. Mofher	r's Name	(First, Middle,	Maiden Suman	ne)	
Aente de la la la la la la la la la la la la la	Joseph	Casele						Maria	Lam	nanna			
	19a. Informar	nt's Neme/Reletionship	(Type, Print)		19b. Maili	ing Addre	ess (Stree	t and Number	r or Rura	l Route Numbe	or, City or Town	State, Zip	Code) 2064
	Willia	m A. Humphi	ey/Husban	d	4695	Sma 1	Llwoo	d Chur	ch R	load, Ir	ndian He	ead, 1	Maryland
of Heel	20a. Method o	of Disposition		20b. F	Place of Disponentery, cre	osition (A	vame of			Date	20c. Location		
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/Medical Examiner	fmmediate Ca disease or co resulting in de	ndition	. Meta	stat		Nor	n Si			r respiretory er		incer	Onset and Deat
Examiner	disease or co resulting in de Sequentially if any, leading cause. Enter	endition eeth)	e. Meta	tat Due to (c	tie,	No1	n Si					incer	Onset and Dea
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State of Maryland / Department of Health and Mental Hygiene 99 21557

					Ce	rtificate	of	Death			Reg. N	lo.		(m	
		1. Decedent's Name (First, Middle, L.	est)							2. Date of D	eath			3. Tim	a of Death
Physicia		Karen V. Helsel								June 2	23,	1999	Year	2:2	0 pm
/Medic Examin		4a Facility Name (If not institution, gi	ve street and numbe	or)				4b. City, To	wn, or Lo	cation of Dea		c. County	of Deeth		F
Examili	ei	3455 Bantry Way						Olney					omery	,	
Funeral Director		219-94-5350	Sex 7. / 1 ☐ M 2⊠ F	Age (In yrs. 35	last birthday Yrs.		Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D Feb 15	rth ay, Yea), Î	964	Cour	place (Ste pty) Land	ite or Foreigi
2 .		Usual Residence of Decedent		140-00	-										
ay a		10a. Stete 10b. County			ty, Town or L	ocation							Ι,		e City Limits
the Maryland 28e-f show notified at	cto	Maryland Montgome	ry	Oln	ey									- 10	res 2⊠No
h with it	al Directo	10e. Street and Number 3455 Bantry Way				10f. Zip 0					10g. C		What Cour	itry?	
5-00.20 72 hours after death with the Maryla natural; or frame 23s or 28s-f show likel Examiner must be notified at	by Funeral	11. Marital Status 1 Nover Merried 2 Merried 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Dates	3?] No	,S. 13.	Wes Decede If Yes, specif				ecify Yes or N Rican, etc.)	0-	Bled	e - Americ ck, White, .:Whit	etc.	1,
S to S	bel	15. Decedent's E			16a. Dece	dent's Usual	Occur	pation	A = 6 = sk.2		16b.	Kind of Bu	usinass/In	dustry	
within than the Me	Completed	(Specify only highest gr Elemantary/Secondary (0-12) 12	College (1-4o	r 5+)		e kind of work DO NOT use naker	c done retire	during mos d)	t of work	ng	Ow	n Hor	ne		
The dist		17. Fether's Neme (First, Middle, Las)					18. Mothe	er's Name	(First, Middle	e. Maide	n Suman	70)		
yidin Suld be Mental anked o	9 Be	John Michael Hels						Joan	Go1	len					
y Mould d Men marke	2				401-14-1	to a find donor of	(0				0'	T	04-4- 75-	0.4-1	
Mary 12 sho 18 mary 18 mary 18 mary 18 mary		19a. Informent's Neme/Relationship								A Route Numi		_	State, 24	C000)	
Te, M 1 and 2 Health em 27 i		Thomas E. Wadlow	/ Friend	20h F		Banti	_	way, (orney		2083		Oh T	04-4	
Dalumore, semit. Pages 1 ar Apartment of Hsa mportant: if Item 2 iny Injury or other 8008.		20a. Method of Disposition 1 Tsurial 2 Tremation 3 Telephone 4 Donation 5 Other (Special Control of the Contro		0	cemetery, cre	metory or oth Heaven	ner ple		y 13	ine 25			Sprin		
permit. Departu Importa any Inja		21. Signature of Funeral Service Lice	nsee			2. Name and Francis				Funera	l H	ome.	Inc.	, MD	2090
, Physician /Medical		23a. Part Enter the disease, or con shock, or haert feilure. List only	one cause on each	line.					cardiac o	or raspiratory	arrest,		1	Onset a	Between nd Death
Examiner		disease or condition resulting in deeth)	a Squamou	- A-TO	- TENEDA 1 - EAS		1u	ng					- 1	10 m	onths
	6			Due to (c	or as a conse	quence of):									
cate be executed physician and s the buriel-transit	Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Disease or Injury	b	Due to (o	or as a conse	quence of):									
를 모해	Medicai	Cause (Disease or Injury that Initiated events resulting in death) Last	d	Due to (o	r es a conse	quence of):									
attending	Physician														
by the a	Sic	Pert II. Other algnificant conditions	contributing to death	but not ras	ulting in the	underlying car	use giv	ven in Part t	l.	23b. Dic	tobaco	o una co	ntributa t	the cau	as of death
- 5 6 O	by Ph									10	Yea	2□ No	3 Pro	bably	4 🗌 Unknov
Physician: The law requires this certificate has been sign ral director, page 2 should be	Completed									24a. We per	s an au ormed?	opsy	av	era autop ailable pr impletion death?	
The lay ate has page 2	FO									10	Yes	2 🖾 No	1[Yea	₩ No
iclan: Th	Be C	25. Was case referred to medical						26. Place	of Death	(Check only					
Physician: this cartific	To B	axaminer? 1 ☐ Yes 2 ☑ No	Hospitaf:	tient 2	ER/Outpatie	nt 3 DO/	Ott	nor:		me 🕉 Res		6 🗆 Oth	er /Specie	h)	
a the second		27. Manner of Death	28a. Data of fn	jury	28b. Time		c. Inju			28d. Describe				"	
i or Attending I after death. Director: After d in by the fune	Certification:	1 Netural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	99 Place of t		Injury ome, ferm, si	М	10	rk? Yes 2		28f. Location	(Street	and Numb	per or Run	al Route i	Vumber,
To the Hospital or All within 24 hours after d To the Funeral Direct completely filled in by		4 nomicide	building,	atc. (Specif	y) 					City or To					
the Hospital thin 24 hours of the Funeral mpletely filled	edical		nysician: To the besis miner: On the besis and manner:	of examina											se(s)
Within To th	ž	29b. Signature and little of cortifier	٥			29c.	Licens	se number			29d. [ete signe	d (Month,	Day, Yes	17)
		14-50	h	m	>	D3.	563	5			Jun	e 24	, 199	9	
		30. Neme and addless of person who													
		Joseph Kaplan,MI). 18111	Princ	e Phi	Llip D	riv	e, 01	ney,	MD 208	332				
Stat	te	31. Dete filed (Month, Day, Year)		trar's Signa	iture 4	do-		,							

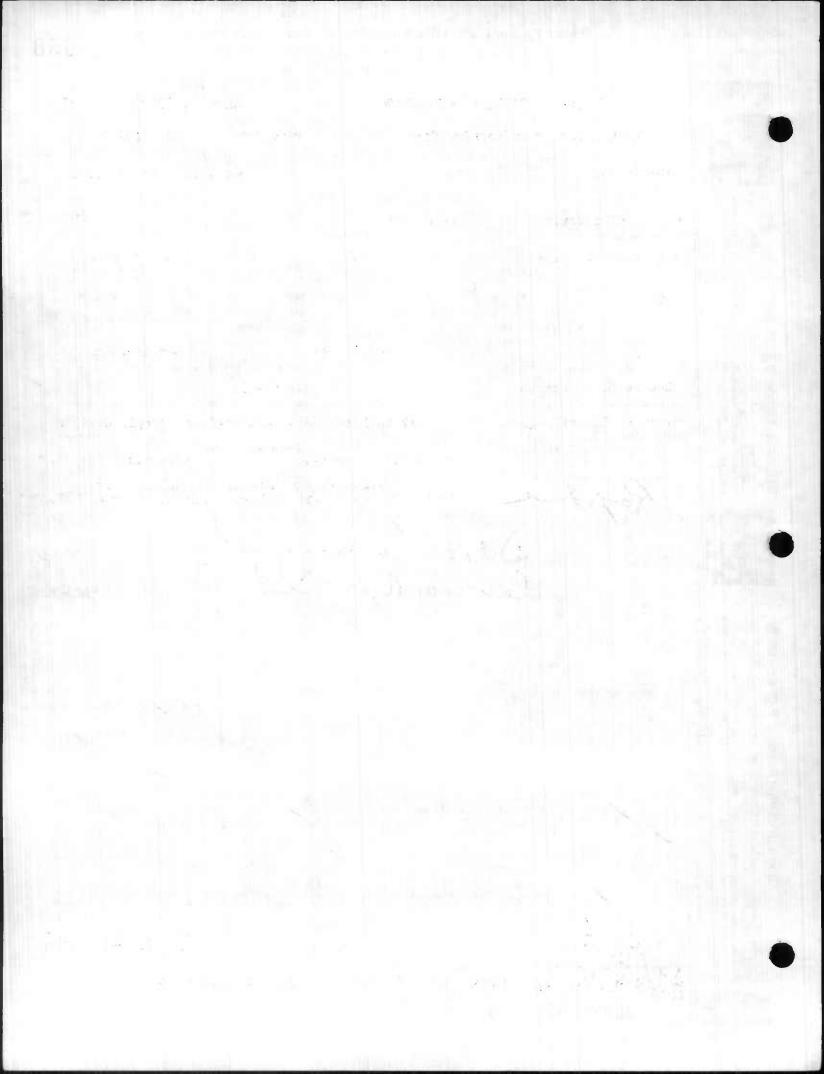


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State of Maryland / Department of Health and Mental Hygiene 99 2 | 558

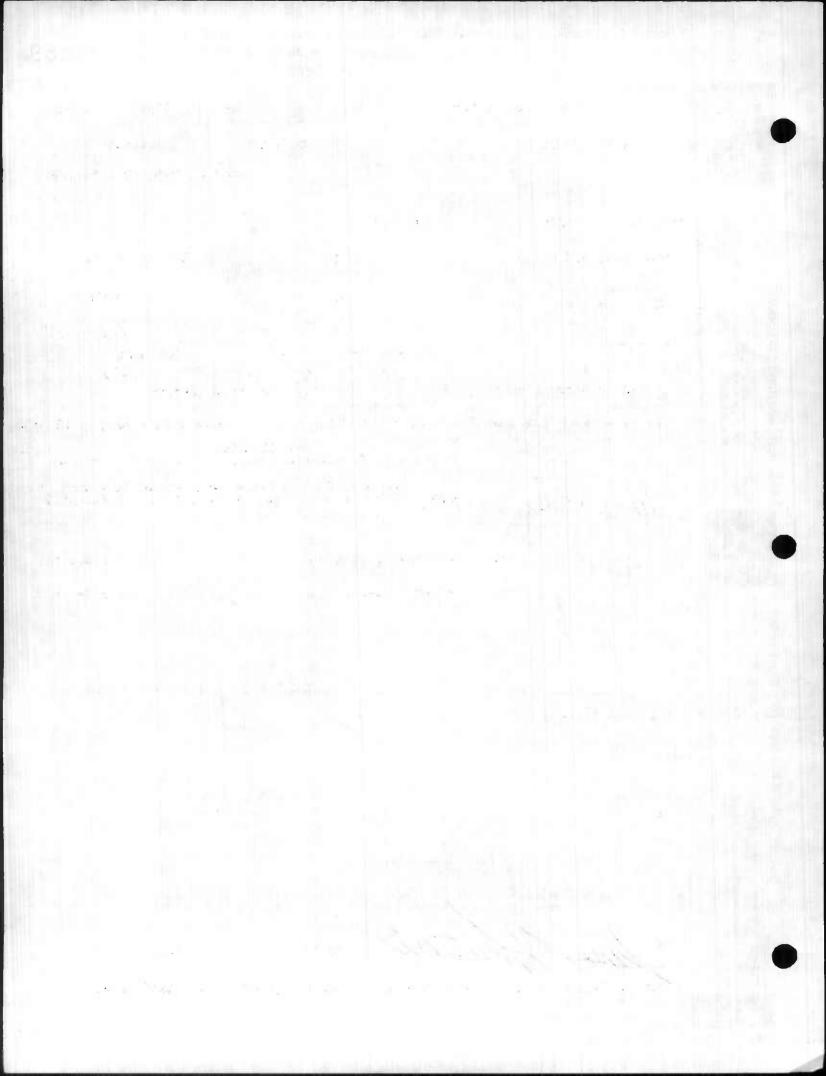
					Ce	rtificate of	f Death		Reg. No.		
	•		1. Decedent's Name (First, Middle, Las	st)				2. Date of	Death	V	3. Time of Deeth
	Physicia		Walter	Gilbert H	ENDERSO!	N		June	19, T 999	Year	3:15 PM
	/Medic Examin		4a Facility Name (If not institution, give Northampton M		Home			wn, or Location of De lerick	eath 4c. County Frede		
	Funeral Director		5. Social Security Number 213-01-1712 Usual Residence of Decedent	ex M 2□ F 88	s. last birthday) Yrs.	Months Dey		24 Hrs. 8. Dete of (Month, Sept.	Birth Dey, Year) 1, 1910	Coun	
	Pue Ma	1	10a. Stete 10b. County	10c. (City, Town or Lo	ocation			7. 14. 7. 1	1	0d. Inside City Limits
	Sa-f sho	ctor	Maryland Frederic	k Fr	ederic						1 Yes 2 □ No
	th with the 23a or 2	Funeral Director	10e. Street and Number 990 Waterford Dri	ve		10f. Zip Code 21702			10g. Citizen of V		
020	should be filed within 72 hours after death with the Manyland of Mental Hylgene. Thylgene marked other than "naturel; or itema 23a or 28a-f show immite event, the Moultal Examiner mant be notified at	þ	11. Marital Status 1 □ Never Merried 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 X N	ıban, Mexicar	gln? (Specify Yes or n, Puerto Rican, etc.)	Blac	e - Americ ck, White, v: Whi	etc.
21215-0020	hin 72 ho n *nætur Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementery/Secondary (0-12)		(Give	dent's Usuel Occ kind of work don DO NOT use reti	e durina mos	t of working	16b. Kind of Bu	usiness/Inc	dustry
21	d with giene.	ĕ	8	Oollege (1-401 54)		Bricklay	er		Constr	uctio	on
Maryland	buld be filed within Mental Hygiene. arked other then *	Be	17. Father's Name (First, Middle, Last)					er's Neme (First, Mide	die, Meiden Suman	10)	
Z Z	should nd Mer marke umarke	2	Edward O. Hender		405 14-33			Cowell	mhas Olhsas Taum	Chata Zin	Code
Ma	d 2 sho th and 7 is m traum		19a. Informant's Name/Relationship (1) Betty H. Ellis/Da					er or Aurel Aoute Nu Catonsvi			
	1 end Health em 27		20a. Method of Disposition		Diego of Diego	neition (Name of		Data	One Leanting		
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: if Item 27 Is marke any injury or other traumatic DDC8.		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from Stete	cemetery, cre t. Mary	s Cemet	^{lece)} Jun ery	e 23, 199	9		Maryland
Ball	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen	100				Funeral Hon			e. ad 20850–2805
			23a. Part1. Enter the disease, or compshock, or heart failure. List only							arytan	Approximate
	Physician		shock, or heaft failure. List only	one cause on each line.	0	7		U.		1	Onset and Death
1	/Medical		Immediate Ceuse (Final disease or condition	Dilati	ed L	ordi	mes	ogstru	1		years
	Examiner		resulting in deeth)	Due to	(or es e conse	quence qt):	N	() /	1	1	
	pa ž	ine		· (orbor	uy (Acu	De		/	1	Georg
	end end il-tran	хаг	Sequentially list conditions, if any, leading to immediate	Due to	(or as a conse	quence of):					0
90	be an ician buria	m m	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	C						i	
x 68760,	eath certificate be avacuted ettending physician end for use es the bunal-transit	/Medical Examiner	that initiated events resulting in death) Lest	Due to	(or es e conse	quence of):					
Bo	death o	cian						1		1	
P.0.	0 0 0	Phys	Part II. Other eignificant conditions or	intributing to death but not re	esulting In the u	underlying cause	given In Part I		☐ Yes 2 No		the ceues of death? bably 4 Unknown
	requir	Completed by						24a. W	las an autopsy enformed?	CO	ere autopsy findings eileble prior to mpletion of cause death?
E E	The law ate has t page 2 s	mo						1	Yes 20 No	10	Yes 2□ No
ā	ician: Th certificate rector, pag	Be	25. Wes case referred to medical				26. Place	of Death (Check on	ly one)		
	Physician: this certific ral director,	To	exeminer? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpetie	nt 3 DOA	Other: 42 Nu	ursing Home 5 R	esidence 6 Oth	er (Specif	y)
	Attending Physical death. ector: After the by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of tnjury (Month, Dey Year)	28b. Time of Injury	N	juryat /ork? □ Yes 2 □		be how Injury occur	red	
5	2 4 2 5	Certification:	3 Suicide 6 Could not be determined	28e. Placa of Injury - At building, etc. (Spec	home, farm, st	reet, factory, offic	69		n (Street end Numb Town, Stete)	oer or Rure	al Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	edlcai C		yelctan: To the best of my ki liner: On the basis of examinand manner stated.							
	o the	N N	29b. Signatury and title of certifier	and manufactured.		29c. Lice	nse number	,	29d. Dete signe	d (Month,	Dey, Year)
			* AUNS			5.	165	16	JUNE	2	1999
	8		30. Name and andream of person who	completed cause of death (It	em 23a) (Type,	, Print)	PLE	2 M	1202		
	Sta	te	Date filed (Month, Dey, Yeer)	32. Pegistrar's Sig		March	1 64	79 2	1200		
	Registra	ar	JUN 2 3 199	9 /4	10.	poork	2				

Registrar

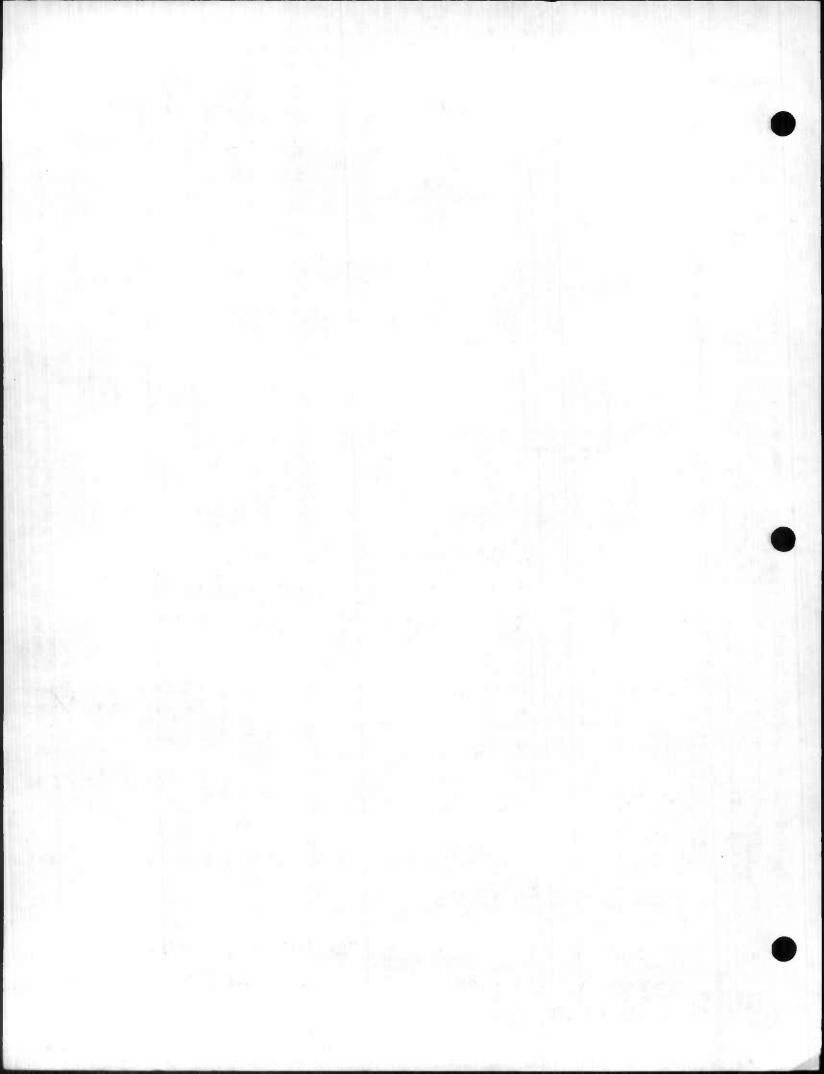


State of Maryland / Department of Health and Mental Hygiene 99 2 | 559

						Ce	rtificat	e of	Death			Reg. No.				
			me (First, Middle, L	ast)							2. Data of De			Vans	3. Tima of	Death
	Physician		Miriam	Berry Hu	bbert						June 1	6. 1	999	Year	7:30H	PM
1	/Medical Examiner	An English Mama	(If not institution, gi	ve street and num	ber)			$\neg \top$	4b. City, To	own, or Lo	cation of Deal		County	of Death	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	Examino		stwood Dr	ive					Ret	hesda	9		Mont	gome	rv	
1	Funeral	5. Social Security	Number 6.	Sex	7. Age (In yrs. la:	st birthday)	If Under		If Under	24 Hrs.	8. Data of Bi (Month, Di	rth	HOHE		olaca (State o	r Foreign
п	Director	065-10-3	3741	1□ M 20XF	94	Yrs.	Months	Days	Hours	Min.	April 1		05		issipp	
	2	Usual Residence	1													
	how	10a. State	10b. County		10c. City,	Town or L	ocation							1	0d. Inside CI	
	W Par	Maryland	Montgo	mery	В	ethes	da								1 🗆 Yes	5 KN MO
	it to	10e. Street and Nu	umber				10f. Zip	Code				10g. Citi	izen of W	/hat Cour	ntry?	
	th with	5208 W	estwood D	rive			20	816				Uni	ted	Stat	es	
	burs after death with the Marylar el, or items 23a or 28a-f show Examinet must be notified at the Funeral Director	11. Marital Status		12. Was Deced	dant Evar in U,S.	. 13.	Was Dece	dent of I	Hispanic Or	rigin? (Spe	ecify Yas or No Ricen, etc.)	0-		- Americk, Whita,	an Indian, etc.	
0	or is		rried 2 Married	1 ☐ Yes If Yes, Give	2 X No		1 ☐ Yes						Specify:			
00	ours a	3 XWidowed	4 Divorced	Yaar or Da	tes:								opeony.	*****	rce	
21215-0020	be filed within 72 hours after death with the Maryland tal Hygiena. d other than "naturel", or items 23a or 28a-f show event, the Medical Examine must be notified at the Completed by Funeral Director.	(Spe	15. Decedent's E	ducetion ada complated)		16a. Dece	dant's Usua kind of wo	al Occu	pation during mos d)	st of worki	ing	16b. K	ind of Bu	siness/In	dustry	
121	within ena.	Elementary/Sec		College (1-	4or 5+)				od)							
2	filed within Hygiena. other than end, the Men Comp		1	4		Home	maker		1			-	n Ho			
Maryland	should be filed and Mental Hygi marked other imatic event, To Be Co		(First, Middle, Las						18. Moth	ers Name	(First, Middle	i, <i>Maid</i> an	Sumam	Θ)		
X	d 2 should be fith and Mental H Is marked odl traumatic ever		iam Steve		ry						Graddy					
Nar	0 8 8 8		Name/Relationship								al Route Numb					
	C C OI L		Goodson/	Executor					eet,	N.W.	, Suite					20036
ore	of Haa If Item or other	20a. Method of Dis	sposition ! XCramation 3 (Bamoval from S	20b. Pla	ca of Disponentery, cre	osition (Name or of the or	me of other pla	ice) June	18.	Data 1999	20c. Lo	ocation - (City or To	own, State	
<u>E</u>	Pages ment of ant: If its ury or o		5 ☐ Other (Speci						torium			Betl	hesda	a, Ma	arylan	d
Baltimore,	permit. Pages Department of Important: If it any injury or one	(21. Signature of F	uneral Services Lice	nsyes -3		RC RC	2. Nama ar	nd Addre	ess of Facil	ity Flymor	ral Home	/Roth	ondo	Charm	Chan	Torre
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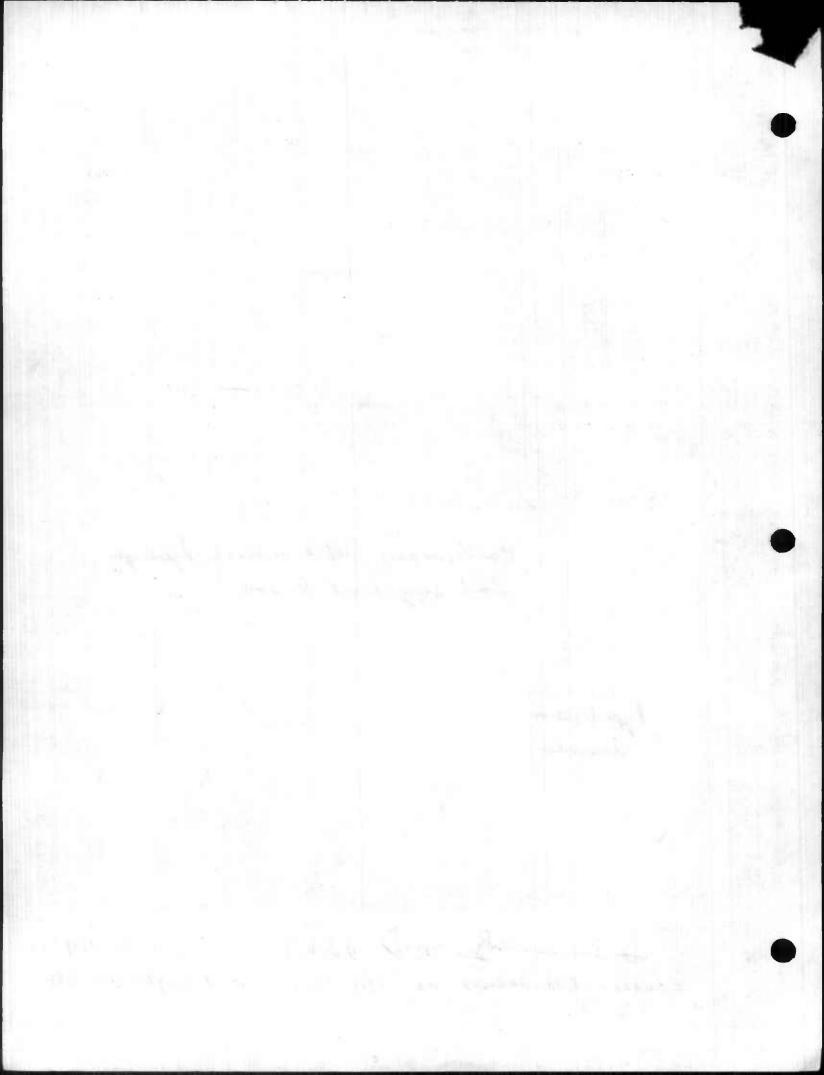


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death JVN E **Physician** MARY ELDISE 1999 HUDSON 1:02 8 6 /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Funeral Hours Min. Months Days 1 ☐ M 2 ☑ F **Director** 718-10-5671 23,1912 Washington, D.C. Usual Rasidence of Decedent the Maryland 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow "natural", or frame 23a or 28a-f abovedical Examiner must be notified at 1 ☐ Yas 2 ☒ No Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 8909 Second Avenue 20910 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-II Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race -Amarican Indian, 12. Was Decedent Ever in U,S. Armed Forcas? 11. Marital Status Black, White, atc 1 ☐ Yas 2 ☒ No If Yas, Giva 1 Never Married 2 Married 21215-0020 1 Yas 2 No Specify: P 3₺ Widowed 4 Divorced Year or Dates White Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) The Medical 16b. Kind of Business/Industry Peges 1 and 2 should be filed within nent of Health end Mental Hyglene. ant: If item 27 is marked other than ' ury or other traumatic event, the Mi Elementery/Secondery (0-12) Collega (1-4or 5+) 12 Homemaker Own Home Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumeme) Be William E. Wilson Marietta Vaughan 19b. Melling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 8909 Second Avenue Maureen A. Hudson (daughter) Silver Spring, Maryland 20910 20e. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State Data permit. Peges Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 6/21/99 Silver Spring, Maryland 21. Signatural Funaral Sarvice Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition resulting in deeth) Examiner Physician/Medical Examiner sicien and bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Dua to (or as a consequence of): physicien the buna P.O. Box 68760. Lantex Due to (or as a consequence of) 98 for use signed by the a Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably Unknown Division of Vital Records, Completed by 24b. Ware autopsy lindings available prior to complation of cause of death? 24a. Was en autopsy performed? should page 2 2 XN0 1 Yes 1 ☐ Yas 2 ☐ No or Attending Physician: Be 25. Was casa refarred to medical examiner? 26. Place of Death (Check only ona) 1 Yas 2 No To Hospital: 1 Inpatiant Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this funeral 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Time of 28c. Injury at Work? edical Certification: After 5 Panding invastigation 1 Tyes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At homa, larm, street, factory, office building, atc. (Specify) filled in by 4 Homicida To the Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mannar as stated. 29a. Certifiar completely ner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatura and Marcil and 29d. Data signed (Month, Day, Year) 40365 16 30. Name and addrass of person who completed causa of death (Itam 23a) (Type, Print) CO313 CEURGIA AUE #308 SIWER SPRING MD 20907 SABIA MD PATER 2 31. Data filed (Month, Day, Year) Registrar's Signatura State JUN 21 1999 Registrar



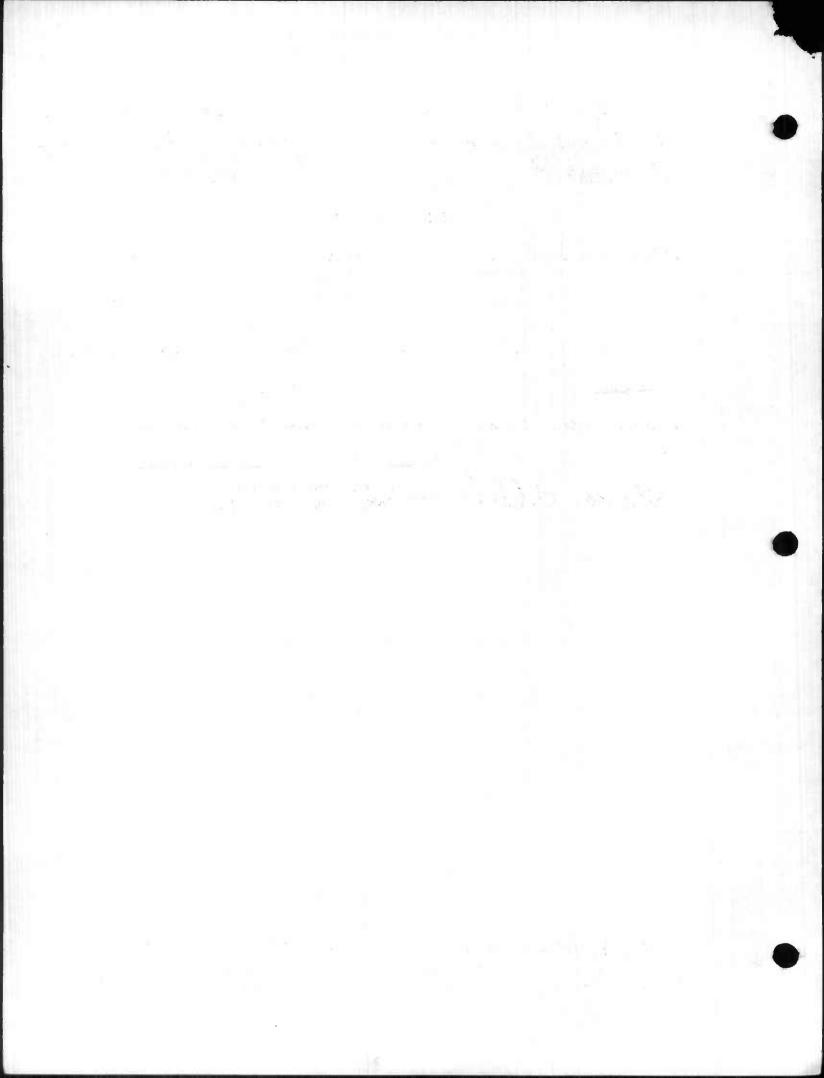
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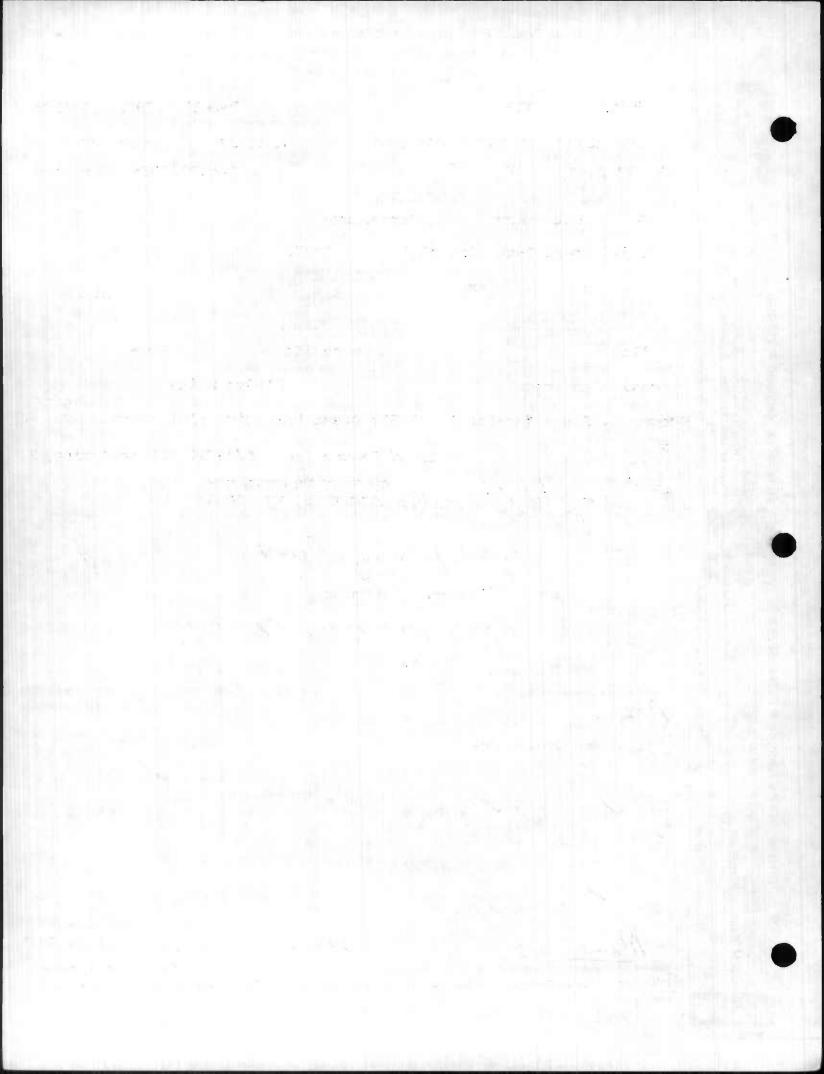
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21215-0020	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show imatic event, the Medical Examinet must be notified at	þ	3 ☐ Widowed		1X Yes 2 1 If Yes, Give 1 C Yeer or Dates:	941-1		Yes 20 No				y:Black	
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Physician /Medical Examiner

Funeral Director

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Physician /Medical Examiner

The law requires that the death certificate be executed physician as the burial USB BS 0 page 2 has certificate Attending Physician: this funeral After As Hospital or Atten-24 hours effer death. To the Hosp within 24 hou To the Funer completely fil

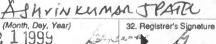
Division of Vital Records, P.O. Box 68760,

1. Decedent's Neme (First, Middle, Last) 3. Time of Death **EDWARD** 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth CHARLES COUNTY NURSING & REHABILITATION LaP1ata Charles 6. Sex 1 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Deys Hours Min. (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Deys 579 03 1835 1907 Washington D.C July 17 Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MARYLAND P.G. Upper Marlboro 10e. Streef and Number 10f. Zip Code 10c. Citizen of What Country? 20774 3315 Chester Grove Road U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces?.
1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ◯XNo Specify: p Specify: 3 ☐ Widowed 4 ☐ Divorced Black. Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 7 th Coilege (1-4or 5+) Parking Lot Manager 17. Fether's Name (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Sumeme) Charles King Estelle Holland 10 19e. Informent's Neme/Reletionship (Type, Pnint) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) King Daugther 3315 Chester Grove Road, Upper Marlboro, Yvonne MD 20774 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removei from State 4 Dopation 5 Dother (Specify) 6/22/99 Brentwood, Maryland Fort Lincoln Cemetery 21. Signature of Parama Stocker Linguistics

Ruth C. Hall 22. Name end Address of Fecility
HALL BROTHERS FUNERAL HOME 621 Florida Ave., N.W. Washington, D.C. 20001 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth immediete Ceuse (Finel diseese or condition resulting In deeth) BOWEL OBSTRUCTION Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in deeth) Lasf Due to (or es e consequence of): Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? FAILURE TO THRIVE 1 Yes 2 No 3 Probably 4 Onknown DEHYDRATION 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? GASTROINTESTINAL BLEEDING 2000 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer?
1 ☐ Yes 2750No Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 5 Residenca 6 Other (Specify) 2 Certification: 27. Manner of Deeth 28a. Dete of injury (Month, Dev Yeer) 28b. Time of 28c. injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Maturei 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 8 Could not be Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es stated.
2 Medicaf Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete and place, and due to the ceuse(s) end menner stated. 29a. Certifler Medical (Check only one) 29b. Signature and title of certifier 29d. Defe signed (Month, Dey, Year) JUNE 16 1990 WALDIRF MA 30. Nema end address of person who completed cause of deeth (Item 23e) (Typ, Print)

ASNIN KUMAN TRAPE 6 PRESTONS II

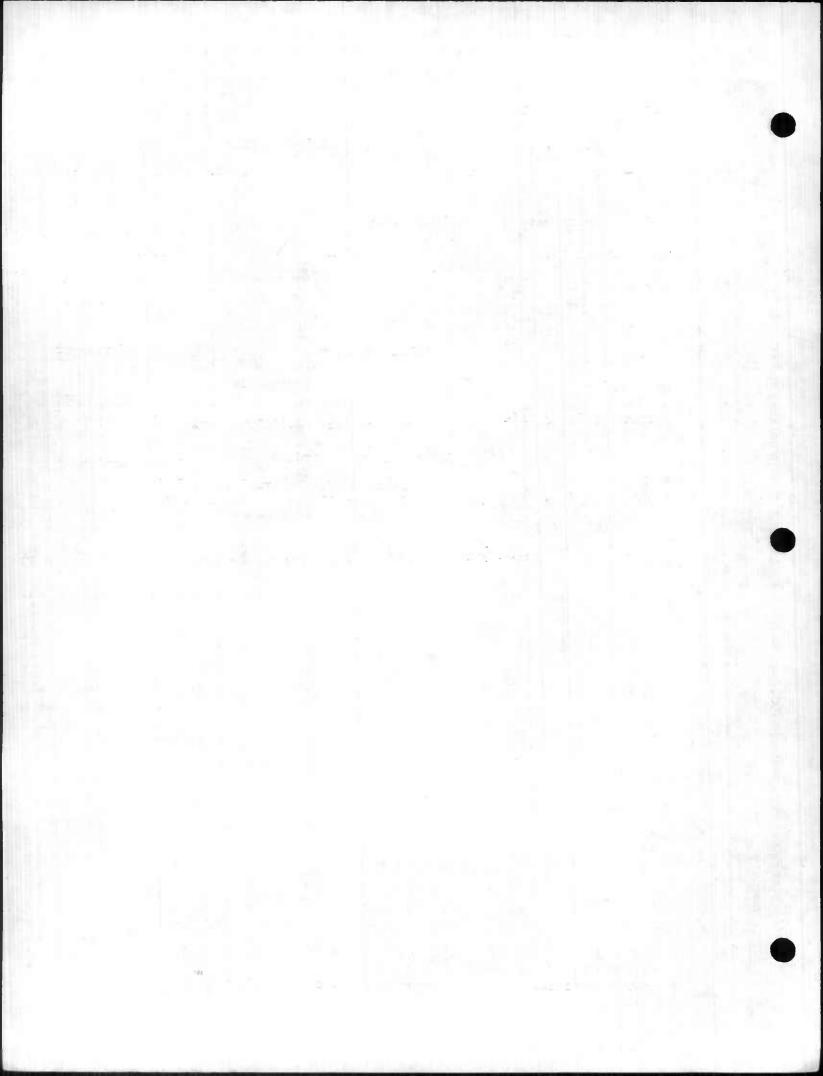
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State of Maryland / Department of Health and Mental Hygiene o

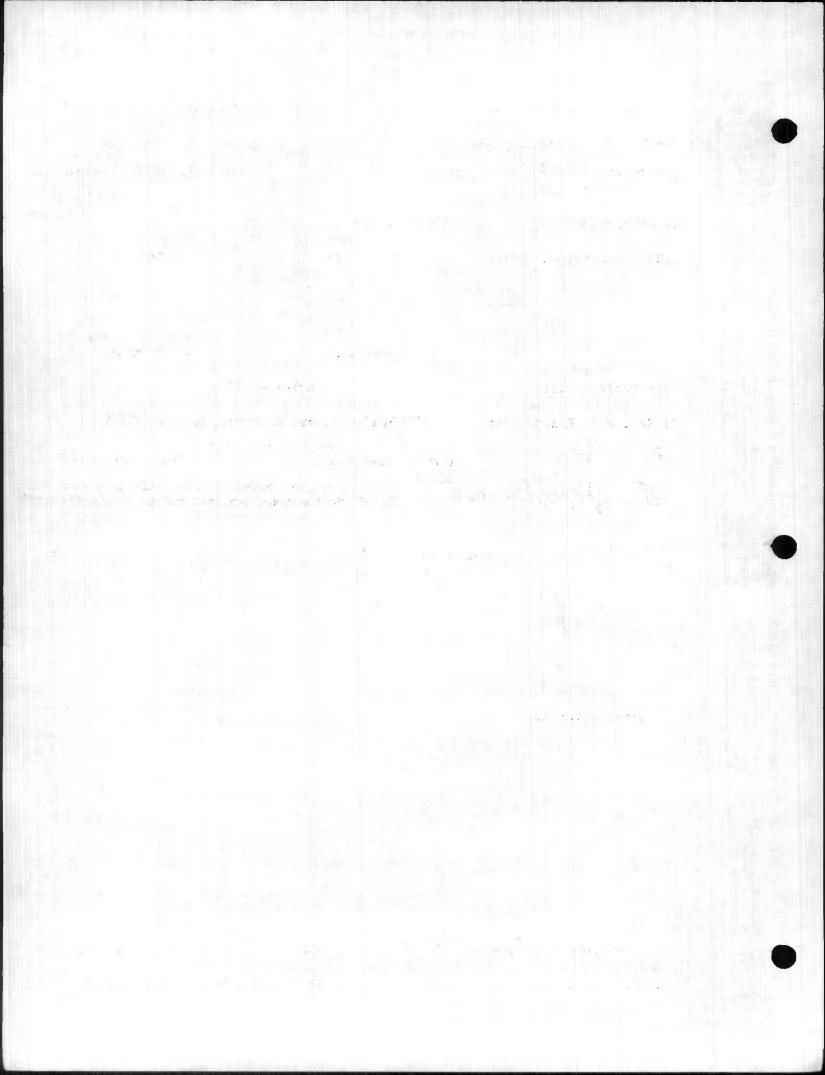
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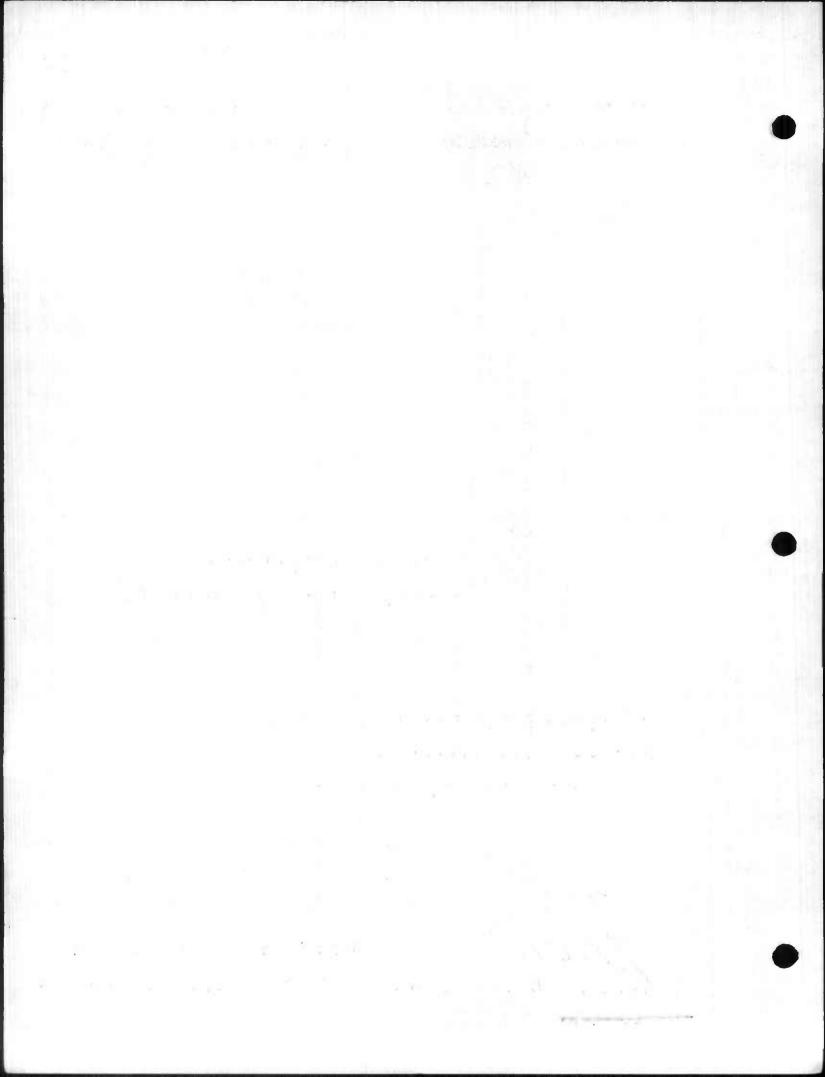
State of Maryland / Department of Health and Mental Hygiene 9 9 2 1 5 5 6

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			Bedford Court N	Mursing H	ome				Silver S	Spring		Mon	tgom	
	Funeral Director		5. Social Security Number 369-20-7421	Sax 1X M 2□ F	7. Aga (In yr. 88			Under 1 Year onths Deys			irth ey, Yea 23,	1910	9. Birthr Covi Washii	eleca (Stete or Foreign entry) ngton, D.C.
	2		Usual Residence of Decedant											
	nyler show		10a. Stete 10b. County		10c. 0	City, Lowr	or Locati	on					1	Od. Inside City Limits
	or 28a-f	3	Maryland Montgom	nery	Si	lver	Spr:	ing						1 ☐ Yes 2 No
	or 2		10e. Street and Number				1	10f. Zip Code			10g. (Citizen of V	Vhat Cour	ntry?
	th w		3700 Internation	nal Drive				20906			Un	ited	Stat	es
21215-0020	n 72 hours effer deeth with the Meryland "natural", or frame 23s or 28s-f show edical Examiner must be notified at	2	11. Meritel Stetus 1 ☐ Never Merried 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorcad	12. Wes Dece Armed For 1 Tes If Yes, Give Yaar or Da	ces? 2 📉 No 9	U,S.		Decedent of is, specify Cult	Hispenic Origin? (pan, Maxican, Pue Specify:	(Specify Yes or Norto Rican, atc.)	lo-	Blec	e - Americ k, White, White	
0-0	2 ho	3	15. Decedent's			160.	Decedent	's Usuel Occu	pation	ndina	16b.	Kind of Bu	siness/in	dustry
216		2	(Specify only highast Elementery/Secondery (0-12)	College (1-	4or 5+)		life. DO	NOT use retin	during most of wed)	Urking	Un	ited	Stat	es
21	od within	5		4		l E	Accou	ntant			Go	vernm	ent	
Maryland	THE PARTY OF	0	17. Father's Neme (First, Middle, La	nst)					18. Mother's N	eme (First, Midd	e, Maid	en Sumam	a)	
/a		2	John Taylor Kei	ster					Mabel H	leadley				
an	d 2 should th end Men 7 la marka traumatic		19e. Informent's Neme/Reletionship	(Type, Print)		19b.	Mailing A	ddress (Stree	t end Number or i	Rural Route Num	ber, City	y or Town,	Steta, Zip	Code)
	Health em 27 learth other tre		Frederick P. Ke	ister/Son	l	480	3 Fla	nders Av	enue, Kens	sington, 1	aryl	and,	20895	
Baltimore,	permit. Peges 1 and Department of Health Important: If Item 27 eny Injury or other to pnce.		20a. Method of Disposition 1 Buriel 2 □ Cremetion 3 4 □ Donetion 5 □ Other (Spe		stata No	Pleca of cemeter	Disposition y, cremeto k Mei	on (Neme of ory or other pla morial	June 2 Park	1, 1999		Location -		
Balti	permit. Departminents Imports eny inju		21. Signeture of Funeral Service Lic	mulk ?	4	0831 nce	Robe		ass of Facility umphrey Fu sin Avenue		e/Be	thesda	-Chev	y Chase, Inc
	Physician	1	23e. Pert1. Enter the seese, or a shock, or heert teilure. List or	omplications that can't one cause on ea	used the de och line.	eth. Dor						,	200.	Approximete Interval Between Onset end Deeth
	/Medical		Immediate Ceuse (Finel disease or condition	F	nuemo	nia								2 Days
	Examiner	5	resulting in deeth)	8.	Due to	(or es e d	consequer	nce of):						
o,	tificate be executed to physician and es the burial-transit		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying	b	Due to	(or es e c	consequer	nce ot):						
ox 68760,	E 00	Vimedica	Cause (Disease or Injury that initiated events resulting in deeth) Lest	d	Due to	(or es a c	onsequan	ce of):						
Box	ires that the death cersioned by the ettendir do be detached for use do by the by Physician A.	5												
o.	the d y the chec	2	Part II. Other significant conditions	s contributing to de	ath but not re	esulting in	the unde	rlying ceuse g	iven in Pert i.					o the cause of death?
Δ,	5 60 5		Severe Deme	ntia						11.	Yes	2 X No	3 Pro	bably 4 ☐ Unknow
Records,	been shoul									24e. We	s an au formed		av cc	ere eutopsy findings reliable prior to empletion of cause deeth?
Re	The law ete hes pege 2									10	Yes	2 X No	1	□Yes 2□No
Vital	ician: The Co		25. Wes case referred to medical						26 Place of D	eeth (Check onli		2,0110		
5	Physician: this certific ral director,		exeminer?	Hospitel:	npatient 2	□ ER/Ou	teations	3 DOA O	those	Home 5 Re		€ □0#b	or (Coosi	6.1
of	Physic rithis coral direction		27. Menner of Deeth				ima of	28c. Inji		28d. Describ			-	197
Division	is effer deeth. In Director: After the ed in by the funeral Certification:	Cario	1 XNeturel 5 ☐ Pending 2 ☐ Accident Investigat 3 ☐ Suicide 6 ☐ Could no	tion t be ass Place	f Injury n, Dey Yeer)				Yes 2 No	28f Location	(Street	and Numb	er or Rur	el Routa Number,
Div	its of Attenders of Director:		4 Homicide determin	ed buildin	g, etc. (Spe	city)	iiii, sti oo t,	, lactory, billoc		City or 7				
	To the Hospital or Attent within 24 hours effer deet To the Funeral Director: completely filled in by the Madical Cartifical			Physician: To the la caminer: On the ba end menn	sis of exemi			igetion, in my	opinion, deeth oc		e, date e	end pleca,	end due t	o the cause(s)
	within To to		29b. Signeture end title of cartifiar	1	(2	29c. Licar	isa number		29d. l	Data signa	d (Month,	Dey, Year)
	12	-	30. Neme and address of person when	a akro	of deeth (It	MS em 23e) (Type, Prir		4523		J	une 1	7, 1	999
			James A. Rossi,			-			1d Blvd	. Silve	Sn	rino.	Mar	yland 20906
	State		31. Dete filed (Month, Dey, Year)	32. Re	gistrer's Sig		,	,		, , , , , , , , , , , , , , , , , , , ,	~P	07	2200 6	
	Registrar	_	JUN 21 199	39 5	never	19	1. 14	porks						

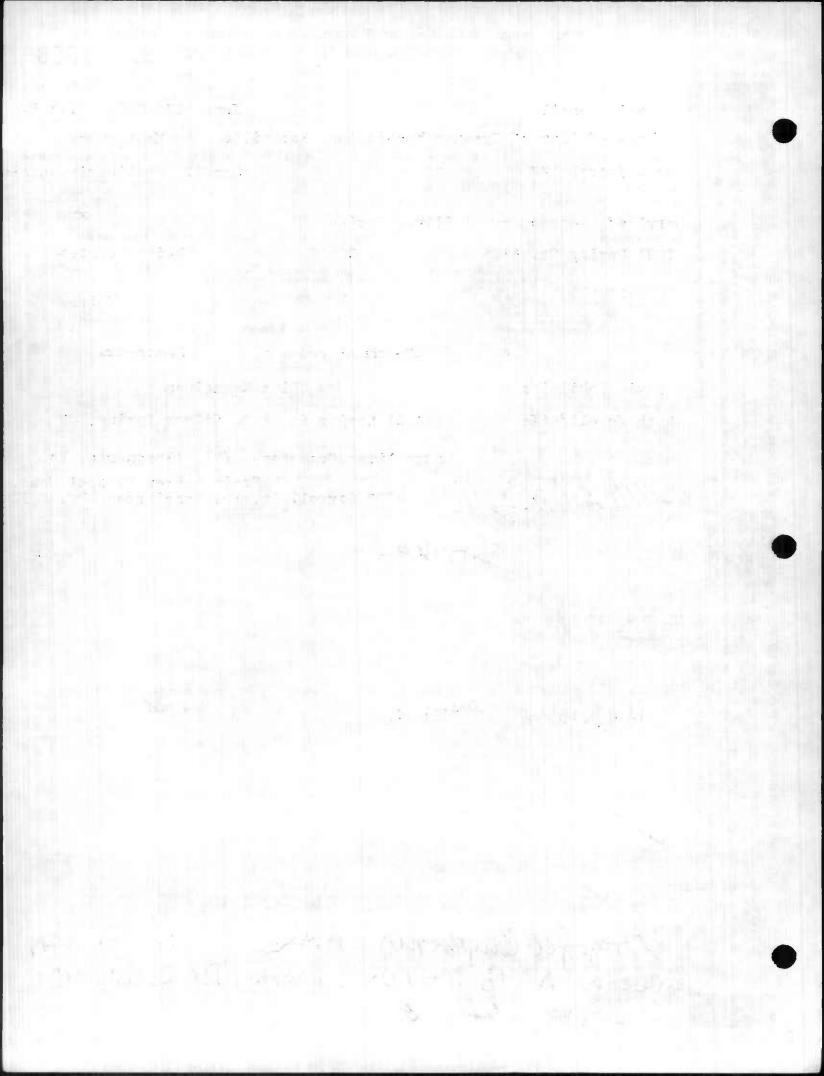
Registrar **DHMH 16 Rev 6/95**



Am	end #31	, 5	State of Maryland / State of Maryland / See #32,6/23/99,BMW,Montg.Co.	Certificate of L			ene JJ g. No.	21301
	Physici /Medic		1. Decedent's Neme (First, Middle, Last) LUCY MAE KING				Dey Ye	9 8:08pm
	Examir Funeral Director	er	4a. Facility Neme (If not institution, give street end number) FORT WAS HINGTON HOS PITAL 5. Social Security Number 437-34-4318 6. Sex 7. Age (In yrs. last in the street end number) 7. Age (In yrs. last in the street end number)	Fo		s. Dete of Birth (Month, Dey.)	4c. County of E PRINCE (ear) 9. (1924 L	Deeth GEORGES Birthplece (Stete or Foreign Country) Oulsiana
	Marylend f show	or		own or Location				10d. Inside City Limits 1 1 Yes 2 □ No
	72 hours after death with the Marylend natural', or items 23a or 28a-f show dicel Examiner must be notified at	al Director	10e. Street and Number 1211 Augusta Street	10f. Zip Code 71301		Ur	g. Chizen of Wha nited St of Ameri	ates
050	rs after dea	by Funeral	11. Maritel Stetus 1 Never Merried 2 Married 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	13. Wes Decedent of His If Yes, specify Cuber	spenic Origin? (Spen, Mexican, Puerto Specify:		14. Rece - A Bleck, V	American Indian, Vhite, etc. Black
Maryland 21215-0020	c 6	Completed I	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+)	Ba. Decedent's Usuel Occupa (Give kind of work done di life. DO NOT use retired) (aundry Techni)		Sb. Kind of Busine Central Hospit	ess/industry State
yland 2	be filed itel Hygi d other event,	To Be Co	17. Father's Neme (First, Middle, Last) Centennial King		18. Mother's Neme			to Zin Code) 20744
	1 and 2 : Health er em 27 is		Delores Pope/ Daughter 20a. Method of Disposition 20b. Plece	9b. Melling Address (Street e 1411 Old Cann of Disposition (Name of	on Road,	Fort Was	shington	, Maryland
Baltimore,	permit. Peges Department of Important: If it any injury or o		MASurial 2 U Cremetion 3 Linemovel from State	en of Memories 22. Neme end Address Winnefield	1	une 26 1	Alexandr Louisian	ia,
6	ad a sa		23a. Pert1. Enter the disease, or complications that caused the deeth. D shock, or heart feilure. List only one cause on each line.	2033 3rd S	Street, A	lexandria		Approximata Interval Between
7	Physician / /Medical Examiner		Immediate Ceuse (Final disease or condition resulting in deeth)	a consequence of):	vyTh n	714		Onset end Deeth
Box 68760,	death certificate be executed e ettending physician and nd for use as the buriel-transit	an/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e consequence of):	revy	715	- a s - q	
P.O. E	0 0 7	Physician/M	Pert II. Other aignificant conditions contributing to death but not resulting	_				oute to the cause of death? Probably 4 Unknown
Records,	requires been sign should be	Completed by	ATVIEL FIGUILLET	109	16104	24a. Wes en		4b. Were autopsy findings available prior to completion of cause of death?
/ital Re	The ate h	Be	25. Was case referred to medical examiner?	Pancre	26. Placa of Deeth	1 ☐ Yes	-2/3/	1□Yes 2⊠No
Division of Vitai	aling Physics. After this funeral di	edical Certification: To	27. Menner of Death 1 PNeture) 5 Pending (Month, Day Year) 28b 2 Accident investigation investigation	Outpetient 3 DOA Othe Tima of Injury Mork M 1 Y ferm, street, fectory, office	et :? /es 2 No	me 5 Residen 28d. Describe how 28f. Location (Stre City or Town,	v injury occurred	Specify) - r Rurel Route Number,
۵	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the	ical Cer	29a. Cartifier (Check only 2 Medical Examiner: On the best of my knowled 2 Medical Examiner: On the bests of examination of the best of examination of the best of examination of the best of examination of the best of examination of the best of examination of the best of the bes	ge, deeth occurred at the time	e, deta end piece, a	and due to the cau	ise(s) and menne	or as stated.
	To the h within 2. To the F	Med	29b. Signeture end title stortifier	29c. License		290	d. Dete signed (M	fonth, Dey, Year)
	4		30. Name and eddress of person who completed cause of deeth (Item 23a	1) (Type, Print)	1889		06-21	
ı	Sta Registr		31. Dete filed (Month, Day, Year) 32. Registrer's Signature 32. Registrer's Signature 31. Determine the signature of the sign	m D: 13	2 t S	parts	ery	AUR SE



	1. Decede	nt's Neme (First, Middle, La	ist)		Certini	cate of	Dealii	2. Date of De	Reg. No.		3. Time of Death
ysician		aul Kobel						Month June	2.0 .	Year 1999	11:10P
Medical caminer		Neme (If not institution, giv				4	lb. City, Town, or L			ty of Death	11,101
unine.	Heb	rew of Home	e of Gre	ater	Washin	gton	Rockvi			ntgom	ery
neral		ecurity Number 6. S	Sex 7. Ag	ge (In yrs. las	Mo	Inder 1 Year oths Deys	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De Oct. 1	th v, Year)	9. Birthp	lece (State or Foreigny). ria, Rus
ector		-10-1230	1	89	Yrs.			Oct.1	7,09	Sibe	ria, Rus
**	10e. Stete	dence of Decedent 10b. County		10c. City, 1	Town or Location	1				11	Od. Inside City Limi
niner mant be notified at	Mary	land Mont	gomery	Sil	ver Sp	ring					XXYes 2 N
rec rec	10e. Street	and Number	gomery	011		M. Zip Code			10g. Citizen of	Whet Coun	try?
4 0	100	1 Spring S	t, #406			2091	0		Unite	ed St	ates
ner	11. Merital	Status	12. Wes Decedent Armed Forces?		13. Wes [Decedent of H	ispenic Origin? (Sp en, Mexican, Puerto	ecity Yes or No	- 14. Re	ce - Americ	
46 30	1 □ Ne 3 □ Wi	ver Married 2 Married dowed 4 Divorced	1 ☐ Yes 2 🔯 If Yes, Give Yeer or Detes:			es 2√ No	Specify:	riodii, otc.)	Speci	4	ite
edical Exp		15. Decedent's Ed	ducation		16e. Decedent's	Usuel Occup	etion during most of work	ring	16b. Kind of I	Business/Inc	lustry
rt, the Medical	Element	(Specify only highest gra ery/Secondery (0-12)	College (1-4or	5+)	life. DO N	OT use retired	1)	ung			
Con			4		Electr	ical E	ngineer		Electi		
Be ve	17. Fether	s Neme (First, Middle, Last,					18. Mother's Nam			me)	
To	Da	vid Kobiln						Kamme1			
read		nent's Name/Relationship (h Kobe11/W					end Number or Ru				
other t		n RODELL/W.	116	20h Plec		1 0		Dete	20c. Location		
9	1 □ B	urial 2 Cremetion 3	Removel from Stete		e of Disposition etery, cremetor		ematory				
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any injury or once.	8	Mudal	15:1	2	232	Carr	oll St.	NW. W	lashin		ral Hon DC.200
	23a. Pert 1 shoc	. Enter the diseese, or com k, or heert feilure. List only	plicetions un cause one cause on each l	d the deeth.	Do not enter the	mode of dyln	ig, such es cardiac	or respiratory a	rrast,		Approximete Intervel Between
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d for u	Pert II. Oth			-				10	Yes 20 No	3 Prot	pably 4 Unkn
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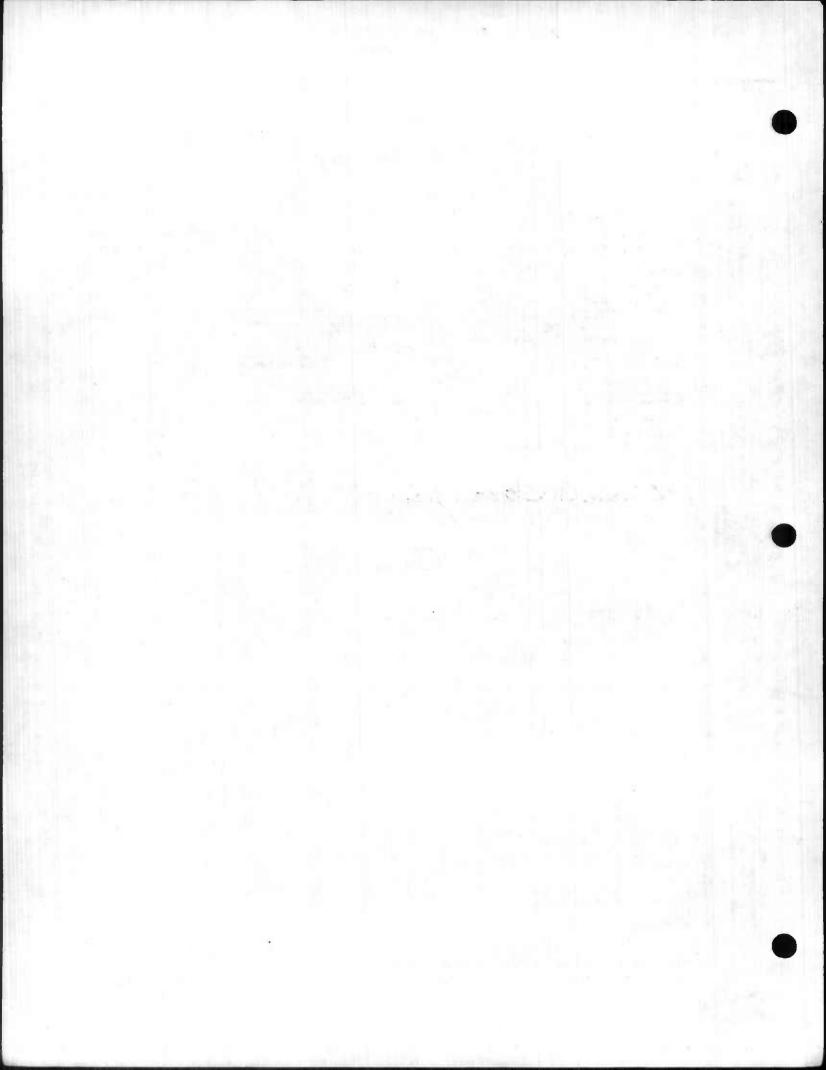


State of Maryland / Department of Health and Mental Hygiene 99

21569 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** JUNE 24, 1999 IDA KORNFIELD 1:00 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner CARRIAGE HILL - BETHESDA **BETHESDA** MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) DEC. 15,1911 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 F Yrs. 577-05-8930 87 NEW JERSEY Director Usual Residence of Decedent the Manfand 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ¥ Yes 2 No Nerns 23a or 28a-f al Director MARYLAND MONTGOMERY SILVER SPRING 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1111 UNIVERSITY BLVD. #1319 20902 UNITED STATES Funeral deep 12. Was Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiens. Important if Item 27 is marked other than "natural", or its any injury or other traumatic event, the Medical Examics any injury or other traumatic event, the Medical Examics 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 2 3 ଔ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPER UNITED JEWISH APPEAL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 8 JOSEPH LEVINE LEAH HOROWITZ 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDY B. FOLSOM (DAUGHTER) 14315 BARKWOOD DRIVE - ROCKVILLE, MD. 20853 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Dete 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State KING DAVID MEM. GARD. 6/27/99 FALLS CHURCH, VA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Neme and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE - ROCKVILLE, MD. tottle nuch 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CARDIAC ARREST Examiner Due to (or as a consequence of): Physician/Medical Examiner ANOXIA 6 MIN. physician and s the burlai-transit Due to (or as a consequence of): Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be exec-RESPIRATORY FAILURE 48 HOURS Box 68760. Due to (or as a consequence of): METASTATIC LUNG CANCER YEAR Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 25000 3 Probably 4 Unknown COPD bengle d be de ğ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? on of cause page 2 # 1 ☐ Yes 2 ☐ No certificate for Attending Physician: sfar death. Director: After this certifica 25. Was case referred to medical å 26. Place of Death (Check only one) 1 Yes 2500 Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Pasidence 6 Other (Specify) Certification: To Manger of D 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Natural 5 ☐ Pending investigation 1 Yes 2 No Accident 3 Suicide 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) E 4 Homicide within 24 hours a To the Funeral C completely tilled Hospital Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Cortifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier ě 29d. Date signed (Month, Day, Year) ind title of certifie 29c. License number 0 JUNE 24, 1999. 8 se and address of person who completed cause of death (Item 23a) (Type, Print) ABOLPH JOHNSON, MD - 12520 PROSPERITY DRIVE - SILVER SPRING, MD. 20904 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State JUN 2 5 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene 99 2 | 570

			Certi	ificate of	f Death	Re	g. No.					
The second of the second	1. Decedent's Name (First, Middla, Last)					2. Date of Death Month		3. Time of Death				
Physicia	Sumpler Leon La	Sumpter Leon Langley						7100am				
/Medica	A. Franks, Married and Albert				4b. City, Town, or	Location of Death	4c. County of Dec					
Examine	NORTH ARUNI		TN		GENE	RIPNIE	AACA	DAITY				
	5. Social Security Number 6. Sex			If Under 1 Yea				rthplace (Stata or Foreign				
Funeral Director	216-70-2875 15M 2DF 44 Yrs. Months Days Hours Min. Awg. 19, 1954 Maryland											
2 .	Usual Residence of Decedent 10a. State 10b. County	10c Cit	ty, Town or Loca	tion				10d. Inside City Limits				
aye of a			.,,					1 ☐ Yes 2 ☐ No				
2 19	Maryland Anne Arur	idel			ern		022	21				
							Og. Citizen of What C United S					
07 8 15		12. Was Decedent Ever in U Armed Forces?	Ever in U,S. 13. Wes Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto				14. Race - Am	American Indian, White, etc. ATTICAN				
	1 Never Married 2 Merried 3 Widowed 4 Divorced	1 Never Married 2 Merried 1 Yes 2 No				, , , , , , , , ,	- "	merican				
		cation	16a. Deceder	nt's Usual Occ	upation		6b. Kind of Business	Andustry				
212		(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)										
12 X	Elementary/Secondary (0-12)	College (1-4or 5+)	T	ruck Op	erator		Private					
O SIBE	17. Father's Neme (First, Middla, Last)	17. Father's Neme (First, Middla, Last) 18. Mother's Nem										
Le dans de la constante de la	Moses Langley				E	thel Oliv	rer					
Marylan Marylan 12 should be in and Market is marked o	19a. Informent's Neme/Reletionship (Typ	pe, Print)	19b. Mailing	Address (Street	et and Number or Ri	ıral Routa Number,	City or Town, Stata,	Zip Code)				
5485	Evelyn L. Wright	- Aunt	1851	5 Straw	berry Kno	11 Rd., (Gaithersbu	irg, MD 20879				
G 5 CHANGE	20a. Method of Disposition	20b. F	Place of Disposit	ion (Name of	T		Oc. Location - City o	C				
altimore, mit. Pages 1 us partment of Hos pertant. If Hear, y Injury or others.	1 ☐ Bunal 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		Lee's C			6/25/99	Clinto	n, MD				
Salt semit. separt my inject	21. Signature of Funeral Service Licensee 22. Neme and Address of Facility Stewart Funeral Home											
	4001 Benning Rd., N.E. Wash., D.C. 20019											
	23a. Parti Enter the disease, or complice or heart feilure. List only on	cations that caused the deat	th. Do not enter	the mode of dy	ying, such es cardia	or respiratory arre	st,	Approximate Interval Between				
Physician	U	Onset and Death										
/Medical	Immediate Cause (Final disease or condition a. METASTATIC CARCINOHA OF PENIS											
Examiner	resulting in death) Due to (or as a consequence of):											
T .=	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	RECIENTERY FAILURE										
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68760, ficate be experient to physician is the burian	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
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Box eath cert attendin for use	d							1				
dead feed feed feed feed feed feed feed	Part II. Other significant conditions conf	tributing to death but not res	ulting in the und	erlying cause o	given in Part I.	23b. Did tol	bacco use contribu	te to the cause of death?				
of Vital Records, P.O. Box 68760, Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and real director, page 2 should be detached for use as the burist-transit	Part II. Other significant conditions cond		1 🗆 Ye	1 Yes 2 No 3 Probably 4 Unknown								
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Orc equipments						24a. Was ar perform		. Were sutopsy findings available prior to completion of cause				
Pecolan law of has by 100 st								of death?				
The L						1 □ Ye	s 2DNo	1 ☐ Yas 2 ☐ No				
of Vital Records, Physician: The law requires the this certificate has been signeral director, page 2 should be					26. Place of De	ath (Check only one	9)					
of Vita Physician: this certific		ospital: Impatient 2	ER/Outpatient	3 DOA	Other: 4 Nursing I	lome 5 ☐ Reside	nce 6 Other (Sp	ecify)				
9 Phys	27. Menner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inj	jury at	28d. Describe ho	w injury occurred					
VISION Attending Is refeeth.	1 Naturei 5 Pending 2 Accident Investigation	(Month, Day 16al)	rigary		☐ Yes 2 ☐ No							
Division or Attending efter deeth. Director: After d in by the fune	3 Suicide 6 Could not be determined	28e. Piece of Injury - At he	ome, farm, stree	t, factory, offic	0	281. Location (Str	reet and Number or I	Rural Routa Number,				
D Para	4 Homicide building, etc. (Specify) City or Town, State)											
Division C To the Hospital or Attending P within 24 hours ettar deeth. To the Funeral Director: After it complately filled in by the funeral	29a. Certifier 1 Certifying Physic (Check only one)	ician: To the best of my kno er: On the basis of examina	owledge, death o	ccurred at the stigetion, in my	time, date and place opinion, death occu	e, and due to the ca arred at the time, da	use(s) end manner atte and place, and di	is stated. ue to the cause(s)				
the of the omple		and manner stated.		29c. Lice	nse number	29	d. Date signed (Mor	oth, Day, Year)				
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	Alex	MI	٥.	4	1>4/1	J	une 2	7777				
(4)	30. Name and address of person who cor	20. 11	n 23a) (Type, Pr	int)	00	0 :	une 21	01.				
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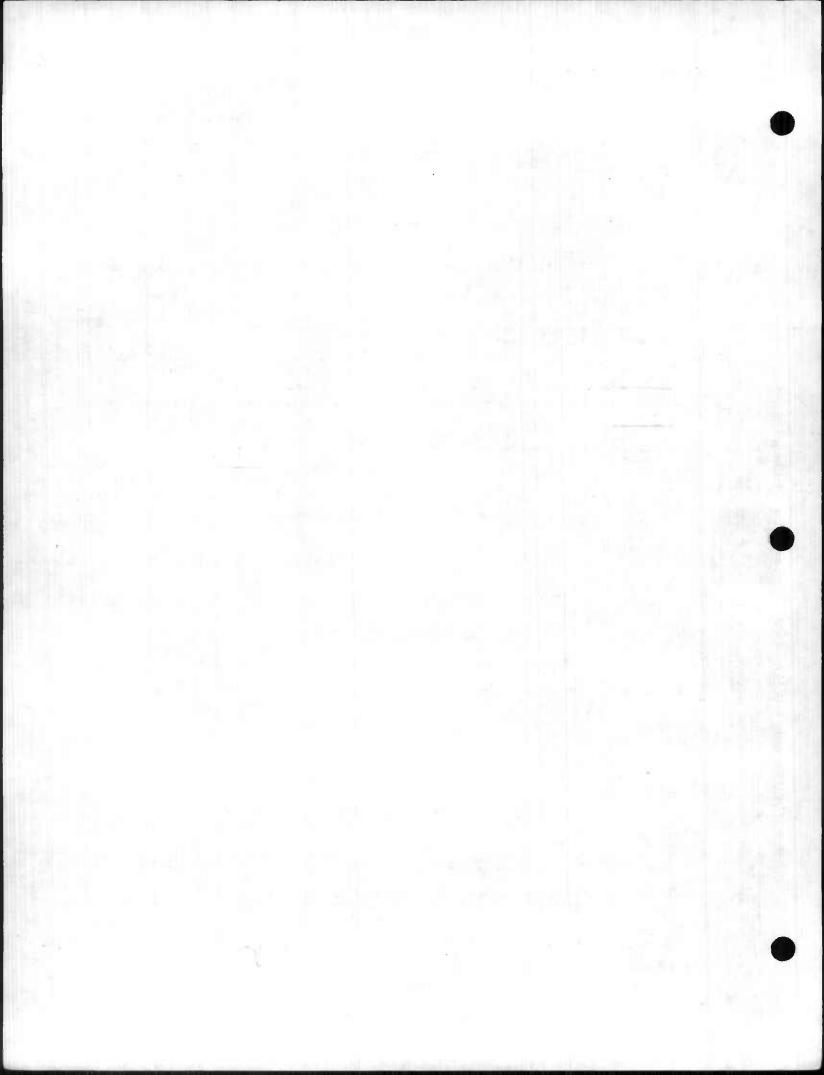
State of Maryland / Department of Health and Mental Hygiene 99 21571

					Cer	tificate	of	Death			Reg. No.			
		1. Decedent's Name (First, Middle								2. Date of De Month	eath Day	Year	3. Time	of Deeth
	Physician	Margaret El	len Luckr	itz						June		1999	5:	30 A.M
100	/Medical Examiner	4e Fecility Neme (If not institution	n, give street and nu	m <i>ber</i>)			-	b. City, To	wn, or Lo	cation of Deet				
	LAUTITICI	Southern Maryl	and Hospi	tal				Clin	ton		Prince	e Geo	rge'	s
F.	unoval .	5. Social Security Number	6. Sex	7. Age (In yrs.	lest birthday)	If Under 1		If Under		8. Dete of Bir (Month, De	th	9. Birthp	lece (Ste	te or Foreign
	uneral rector	484 16 2459	1□ M ¾፟፟፟፟ዄ F	75	Yrs.	Months	Deys	s Hours Min.		May 23	102/	Iowa	try)	
	10001	Usual Residence of Decedent						1		May 23	, 1724	IUwa		
	8 m	10a. Stete 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inaide	City Limits
	P o	1□ Yes ⊀										es ANN No		
	or 28a-f s be notified Director	Maryland Anne Arundel Crofton 106. Street and Number 106. Zip Coda 109. Citizen of What Coun									try?			
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	r home 234 where must Funeral	1829 N. Forest	edent Ever In U,	n U.S. 13. Was Decedent of Hispanic Origin? (Spe				cify Yes or No	United	e - Americ				
21215-0020 d within 72 hours after di gione. or than "netural; or from the Madical Examinat.		1 Never Merried 2 Marr	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					Blee	ck, White,	etc.				
		1 Never Merried 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Yes or Dates:								Specify: White				
9 3	"natural", adical Exu leted by	15. Deceden	16e, Deced	16e. Decedent's Usual Occupation					16b. Kind of Br					
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aryla should and Men	marked matic a	19a. Informant's Name/Relations	thin (Type Print)		19h Mailir	na Addraes /	(Street				er, City or Town,	State Zin	Code)	
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	Item 2 other	Eugene C. Luck	Eugene C. Luckritz								on Maryland 21			
0 % 0	2 2	1 ☐ Burlal 2000 remation	3 Removel from	State	20b. Place of Disposition (Name of cemetery, crematory or other place) The Huntt Cremat			(ece) June 21, Day 999			Waldorf Maryland			
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Baltimore, permit. Pages 1 ar Department of Hea	Important: any injury o once.	21. Signature of Funerel Service	Licensee	0		. Neme and				oral U	lome, Inc	2		
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o š		1 Yes 2 No 27. Mannar of Death	11,4	1 Annpatient 2 ER/Outpatient 3 DOA 4 Nursi					ing Home 5 ☐ Rasidance 6 ☐ Other (Specify) 28d. Describe how Injury occurred					
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Div A	ed in by the funers ed in by the funers Certification:	4 Homicida 4 Homicida 4 Homicida 4 Home, farm, street, factory, office building, etc. (Specify)							City or Town, Stete)					
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To the Hospital within 24 hours	To the Funeral Director: After the complately filled in by the funeral Medical Certification:	one)	and man	ner stated.										
S IN	£ 8 €	29b. Signature and title of certifier			29c. License number				29d. Date signed (Month, Dey, Year)			7)		
7			9/2	D46478				6.19.59						
/ (()	30. Nama and addrass of person	-	se of death (Itan	n 23a) (Type,	Print)			0 .	el	- 1			0.0
_(()/	Suresh A.	Pat	dup	7501	<u> 5u</u>	m	3145	Kd	# 30	7. Chr	note	mDa	9785
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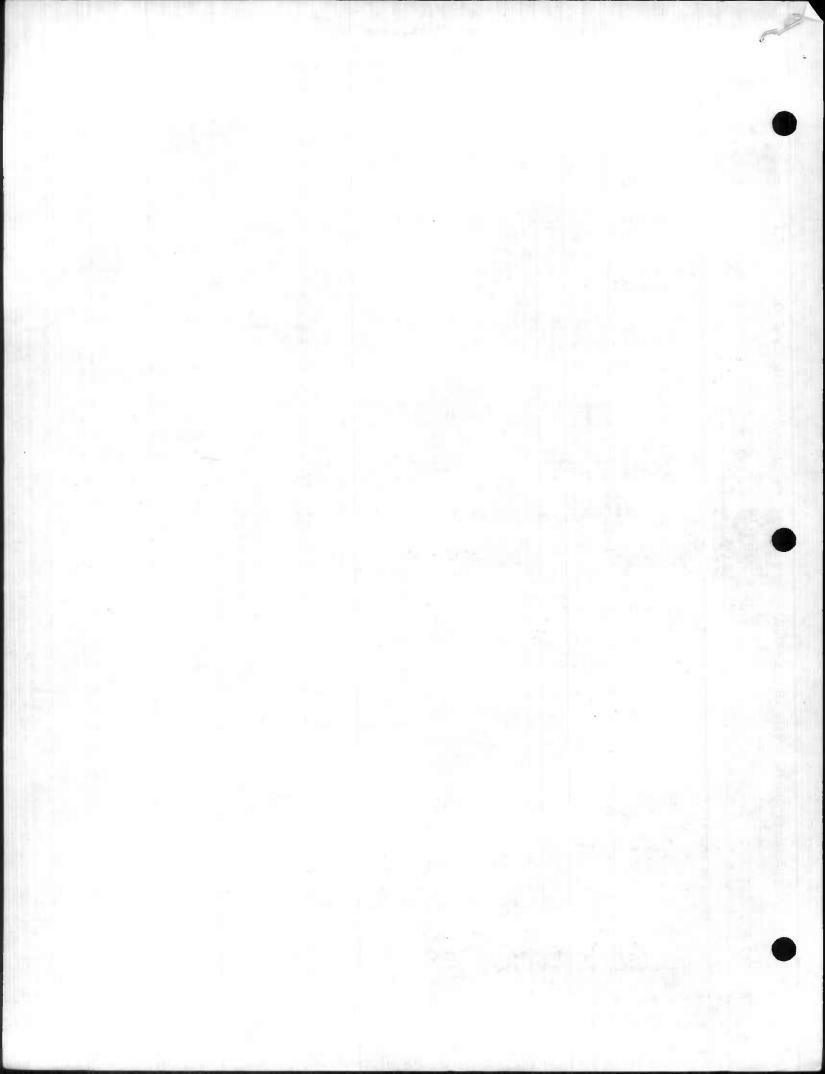
State of Manuland / Department of Health and Mental Hygiene O O

	Amended I	tem#17 ,20b perFH G773	7/12/99 FW		ertificate of			Reg. No.	21572			
	Physician · /Medical	Decedent's Nama (First, Middle, Last Esther		Lart	ey		2. Data of De Month June 21	Day Y	3. Time of Death 12:48 PM			
	Examiner	4a Facility Nama (If not institution, give	e street and number)			4b. City, Town, or L	A					
		19937 Spur Hill	Dr			Montgomer	v Villa	ge Monte	omery			
Funeral Director	_	5. Social Security Number 6. S 578-80-7586		yrs. last birthday 54 Yrs.	1 40 4 4 4 4 4 4 4	If Under 24 Hrs.	8. Data of Bir (Month, Da		Birthplace (Stata or Foreign Country) Ghana			
	syland thew Lat	Usual Residence of Decedent 10a. State 10b. County		10d. Inside City Limits								
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lar death with the Maryland thems 23a or 28a-f show the must be notified at tunaral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?				
	P w P w	19937 Spur Hill	Dr		20886			Ghana				
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Maryland 21215-0020 d 2 should be filed within 72 hours at the and Mantal Hygiene "natural", or 77 is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by F	15. Decedent's Ed (Specify only highest gra Elemantary/Secondary (0-12)		(Give	DO NOT use retire	during most of work	ing	16b. Kind of Business/Industry State Government					
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an	d be for the formal in the for	Jonathan Nathaniel Larka:	i			Adzekai						
2	marks marks marks	19a. Informant's Name/Ralationship (19h Mail	ing Address (Stree			nber, City or Town, Stata, Zip Code)				
Ma	の日田田		The same of the sa									
6	-916	20a. Mathod of Disposition	/Husband	b. Place of Disp	19937 Spur Hill Dr, Mor			ry VIIIag 20c. Location - Ci				
100	Pages nent of h any or of	1 X Burial 2 □ Cramation 3 □	Burial 2 Cramation 3 Ramoval from Stata cemetery, crematory or other place)									
틆	Thank Slury	4 Donation 5 Other (Specify		Awdome	Cemetery		Jul 7	Accra,	Ghana			
Baltimore,	Depa Impo any it	21. Signature of Funeral Sarvice Licen	Donnell		2. Name and Addr 1800 New	111		aldi Fune Silver Sp	ral Home ring, MD 20904			
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death										
, Physician /Medical Examiner		Immediate Causa (Final disaasa or condition rasulting In daath) Breast Cancer							10 yrs			
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Вох	at the death cert d by the attending etached for use Physician/M		0									
0	bed fred /sic	Part II. Other algnificant conditions of	ontributing to death but not	to death but not resulting in tha underlying cause given in Part f.				23b. Did tobacco use contribute to the cause of deat				
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of Vitai Records,	aw requires so seen so 2 should							24a. Was an autopsy performed? 24b. Were autopsy completic of death?				
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ita	certificate rector, pag	25. Was casa rafarred to medical				26. Place of Deal	th (Check only	one)				
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ion of iding Physics. After this funeral di	£ 5 8	27. Mannar of Death 12 Natural 5 Pending 2 Accidant invastigation	28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. fn									
Division	tal or Attanding P rs after death. al Director: After t led in by the funers Certification:	3 Suicide 6 Could not be 4 Homicida datarmined	28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, Stata)					
	To the Hospital or Attanding P within 24 hours after death. To the Funeral Director: After to ompletely filled in by the funeral process. Medical Certification:			To the best of my knowledge, death occurred at the time, date and the basis of axemination and/or investigation, in my opinion, death d manner stated.								
	Withir To the comp	29b. Signature and titla of certifiar	-0		29c. Licen	se number	29d. Data signed (Month, Day, Year)					
	10	Spelen	- IM	D18219				June 22, 19				
	10	30. Nama and addrass of person who o	completed causa of death	(Item 23a) (Type								
		Stephen Staal	1221 Mercan	tile Ln,	Largo,	MD 20774						
	State	31. Data filad (Month, Day, Year)	32. Registrar's S	ignatura	1	4						
	Registrar	JUN 2 4 199	19 Pener	N 19.	A. Oach	21			10.000			

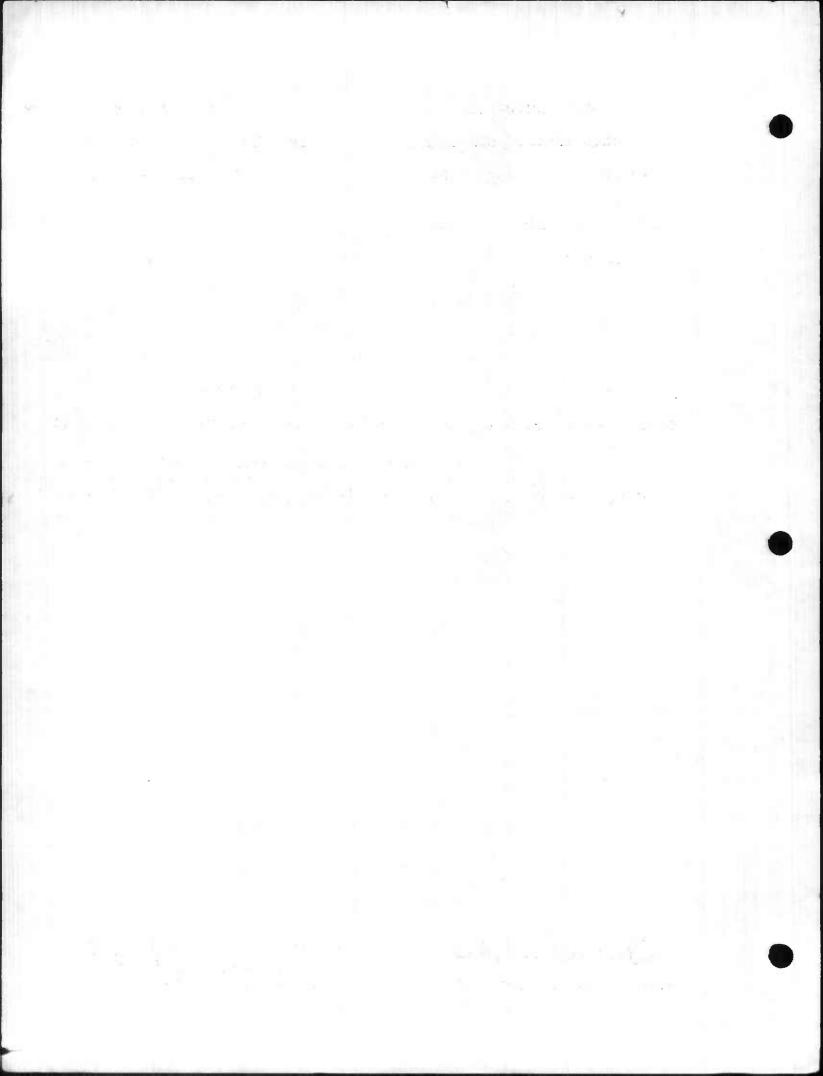


State of Maryland / Department of Health and Mental Hygiene g Amend #20b,6/23/99,BMW,Mont.gCo. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 18, STANLEY M. LAVINE 1999 JUNE 9:30 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1801 E. JEFFERSON STREET ROCKVILLE MONTGOMERY 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 10 M 20 F JUNE 5, Director 579-18-8114 80 1919 VIRGÍNIA Usual Residence of Decedent the Maryland 10n State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f ahow ahow 1 Yes 2 No Director MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? man ban WITH 1801 E. JEFFERSON STREET 20852 UNITED STATES Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. d 2 should be filed within 72 hours effer of the and Mental Hygiena.

7 is marked other than "natural", or her traumatic event, the Medical Examination r than "natural", or her the Medical Examiner 1 ☐ Never Married 2 ☑ Married 21215-0020 Specify: WHITE 1 Yes 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RETAIL MERCHANT RETAIL Baltlmore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) , Pages 1 and 2 should be filt ment of Haaith end Mental H-lant: if Hem 27 is marked oth lury or other traumatic even 8 JENNY GOLDSTEIN ABRAHAM LAVINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT LAVINE 11109 SNOWSHOE LANE - ROCKVILLE, MARYLAND 20852 (SON) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 99 20c. Location · City or Town, State 1 Durial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny Injury or page. ADAS ISRAEL CONG. CEM. 6/20/00WASHINGTON, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sensitive of Funeral Service Licenses 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD. 20852 en 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final VENTRICULAR TACHYCARDIA disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner The lew requires that the death certificets be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) physician the burla Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) for use signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown AORTIC VALVE REPLACEMENT à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? 0000 HEART BLOCK completion of cause of death? has pege 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physicien: 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Hesidence 8 Other (Specify) 1 Yes 2 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this Inneral 27. Manger of Death 28h Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 1) Natural 5 Pending investigation s efter death. 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 8 To the Hospital or within 24 hours of To the Funeral D completaly filled I 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD - 8830 CAMERON STREET - SILVER SPRING, MARYLAND 20910 BRUCE ZINSMETSTER, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 1 1999 Registrar

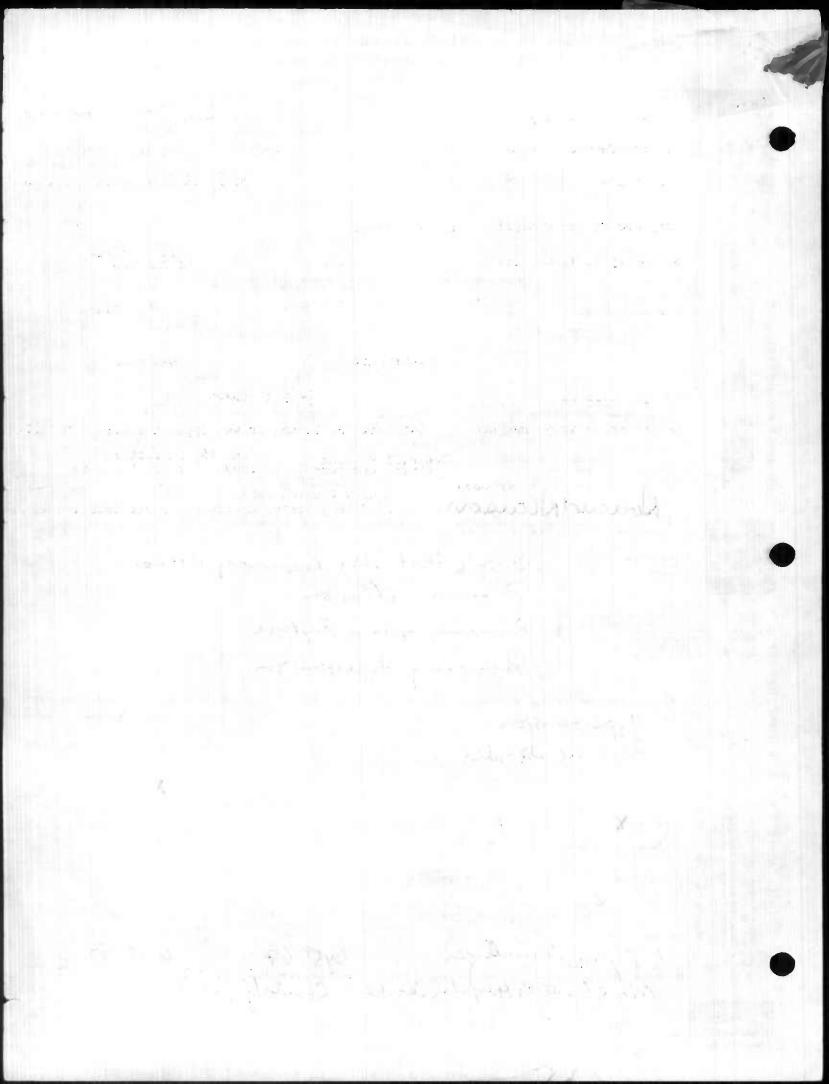


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Maryland 21215-0020	and and and and and and and and and and		19a. Informent's Neme/Relationship (7	Type, Print)	19b. Me	eiling Address (Stree	t and Number or Run	al Route Numb	er, City or Town,	State, Zip	Code)					
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ore	Pages 1 a seril of Hea nt: If Item ry or othe		20e. Method of Disposition 1 □ Buriel 2 ☒Cremetion 3 □	Removal from State	20b. Pieca of Dis	sposition (Name of remetory or other pla	gce)June 24,	Date 1999	20c. Location -	City or To	wn, Stete					
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State of Maryland / Department of Health and Mental Hygiene 99 2 | 575

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Division	를 들는 이	Certification:	3 ☐ Suicida 6 ☐ Could not b 4 ☐ Homicide datarmined	28a. Place of Injury building, etc.	y - At homa, I (Specify)	arm, straat, factory, office	9	28f. Location (City or To	(Straat and Numb wn, Stata)	per or Rure	al Routa Numb	er,
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	47	-	30. Name and aderess of person who	completed cause of ose	th (Itam, 23a)	(Typa, Print) Kar	1 Terwill;	iger, M.	D.	,	•	
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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death 06 5:30 pm 99

Physician /Medical Examiner

Funeral Director

Directo

Funeral

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Completed

with the Maryland ahow permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas Department of Health and Mental Hygiens. Important: If terms 21 is arraked other than "natural", or itame 23a or 28a-1 show any injury or other traumatic event, the Marical Examiner mast be notified as

Baltimore, Maryland 21215-0020

Physician /Medicai **Examiner**

> Examiner physician and tha burial-transit Physician/Medical 88 usa jo j signed by tha a d be datached f peen paga 2 has cartificata this funeral Aftar

the death certificate be executed Division of Vital Records, P.O. Box 68760 or Attending Physician: aftar daath. Director: Aft 24 hours a Hospital To the F within 2 To the F

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à Completed Be 10 Certification: 1 Natural 2 ☐ Accident 3 Sulcide 4 Homicide 29a. Certifier Medical (Check only one)

25. Was case referred to medicat examiner? 1 Yes 2 No 27. Magner of Death 5 Pending investigation 6 Could not be determined 29b. Signature and titla of certifian

JAMES D. MIZELLE 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death 8801 Sterling Street Landover Prince George's If Under 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 110 M 2□ F Months Days Hours Min. 243-20-1757 Yrs 75 November 5,1923 North Carolina Usual Rasidenca of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yas 2 □ No Maryland Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8801 Sterling Street 20785 U.S.A. 14. Race - Amarican Indian, 12. Was Decedent Ever in U.S. Armed Forcas? 1943 1½ Yas 2 □ No If Yes, Give 1945 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married 1945 1 ☐ Yas 2 ☑ No Specify: 3 25 Widowed 4 □ Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) Collage (1-4or 5+) 5+ Chief Administrator Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Nama (First, Middle, Last) Walter B. Mizelle Mary Slade 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 15516 Peach Walker Drive, Bowie, Maryland 20716 Susan Agee/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 06/23 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Ceme. Cheltenham, Maryland 1999 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility
J. B. JENKINS FUNERAL HOME
7474 Landover Road, Landover, Maryland 20785 21. Signatura of Funaral Service Licenses Nancy Per 23a. Part1. Enter the new se, or complications that causad the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 1A Metas Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of):

23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to daeth but not resulting in the underlying causa given in Part f. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yes 2 No 26. Placa of Daath (Check only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Yes 2 No Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) 29c. Licansa number

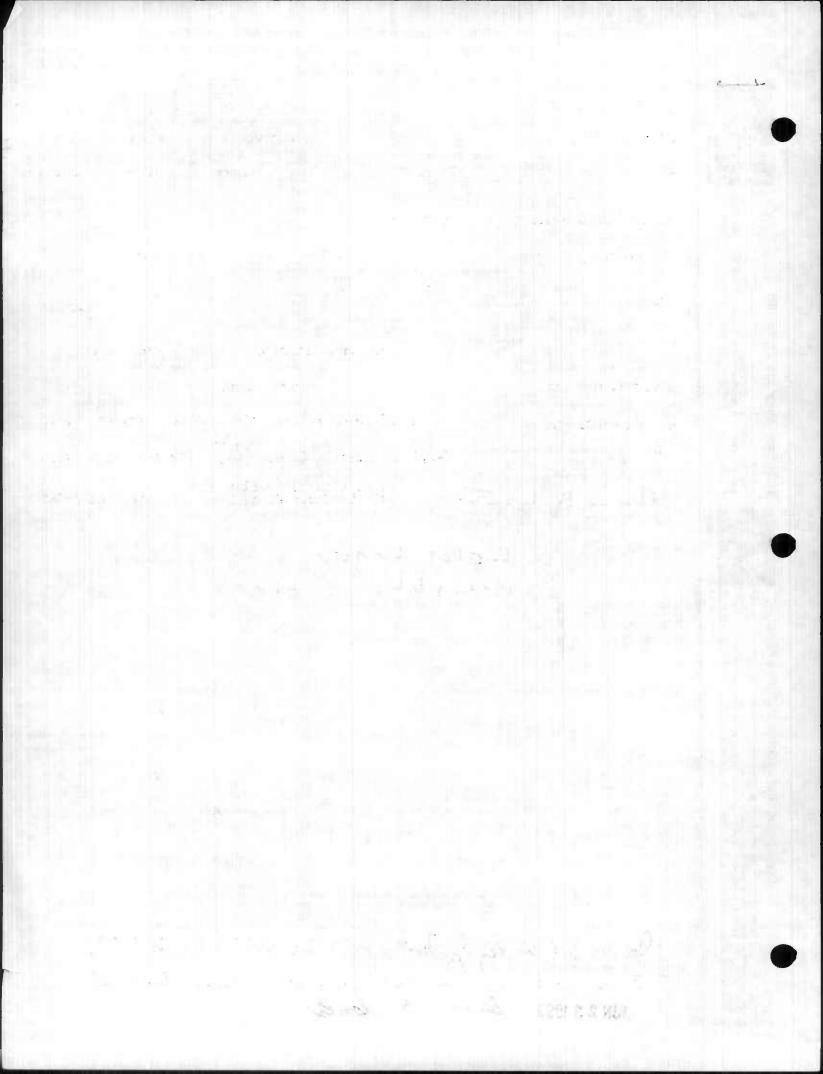
inton und

30. Name and address of person who complated cause of death (ttem 23a) (Type, Print) 00

Brances 011

31. Date filed (Month, Day, Yaar) State JUN 2 3 1999 Registrar

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #19a, 6/25/99, JW, Montg. Cty. Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Yee Robert Toshio Miki June 16, 1999 8:05AM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death 4701 Willard Avenue #619 Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthpiece (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Sex 130 M 2□ F Months Deys Hours 575-26-5270 Yrs. 68 Sept. 21,1930 Hawaii Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4701 Willard Avenue #619 20815 USA. 14. Race - American Indien. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried Specify: white 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Economist Governent 5± 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Thomas L. Miki Terada Alice 19e. informent's Name/Reletionship (Type, Print) Wife 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Anna Marie Kinser Miki (Daug) 4701 Willard Ave. #619, Chevy Chase, MD. 20815 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Burial 2 Cremetion 3 Removal from State Mahanaim Cemetery 6/20/99 4 ☐ Donetion 5 ☐ Other (Specify) Meadowview, VA 22. Name end Address of Fecility Joseph Gawler's Sons INC, 5130 Wisconsin AVE. 21. Signeture of Funerel Service Licensee NW, Washington, DC 20016 23a. Part1. Enter the chart of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. Let only one cause on each line. Approximete Interval Between Onset and Death Immediete Ceuse (Finel diseese or condition resulting in deeth) Congestive Heart Failure Years Due to (or as a consequence of): Cardiomyopathy Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequenca of) 23b. Did tobacco use contributs to the cause of desth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 No 3 | Probably 4 | Unknown 24b. Were eutopsy findings evsileble prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 Yes 2 X No 26. Plece of Deeth (Check only one)

Physician /Medicai Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturel", or items 23s or 2 and injury or other traumatic event, the Wed cal Example must be in page.

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

the Maryland r 28a-f show

> Examiner physician and the burial-transit Physician/Medical 981 6 signed by the a d be detached f þ been si Completed s certificate has b lirector, page 2 s Be Certification: To this

that the death certificate be executed or Attending Physicien: funeral death. Director: A

P.O. Box 68760,

Division of Vital Records,

The law requires

1 Yes 2 No 27. Manner of Deeth

29a. Certifier

25. Wes case referred to medical sxaminer?

5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28e. Date of Injury (Month, Dey Yeer)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, State) 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated.

29b. Signeture end title of certilia

29c. License number D25818

29d. Date signed (Month, Day, Year)

June 17, 1999

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

Sean M. Dwyer MD., 5454 Wisconsin Ave. #925, Chevy Chase, MD 20815

Registrar

2 1 1999

32. Registrer's Signeture

Sparker

within 24 hours aft To the Funeral Di completely filled in Hospital

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	Sex 7. Aga (In yrs. 1	lest birthday) Yrs.	If Under 1 Yaa Months Dey			(ear) 1913 P	B. Birthpiece (State or Foreig Country) ENNSYLVANI	
Da. State 10b. County	OMERY CO.	y, Town or Loc ROC	cation CKVILL	E			10d. Inside City Limit	
De. Street end Number 9701 – VEIRS	5 DRIVE		10f. Zip Code 208		100	Citizen of Wh	et Country?	
I. Meritel Stetus	12. Was Decedent Ever in U,	S. 13. W	/es Decedent of	Hispanic Origin?	(Specify Yes or No-		American Indian,	
Nevar Married 2 Married Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Yaer or Detes:		Yes, specify Cu	iban, Mexican, Pu o <i>Specify:</i>	erto Rican, atc.)	Specify:	White, atc. WHITE	
15. Decedent's E (Specify only highast gr		16e. Decede	ent's Usuel Occ	upetion e during most of v	vodeina 16	ib. Kind of Busin	ness/Industry	
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Pe. Informent's Name/Reletionship (REV.DR. REICHA					Rurel Route Number, C			
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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician end completaly filled in by the funeral director, page 2 should be detached for use as the buriel-transit

Physician

/Medicai

Examiner

Funeral Director

or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryla Department of the tith end Mental Hygiene. Important: if them 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other traumetic event, the Medical Examiner must be notified at

Physician

/Medical Examiner

Be Completed by Physician/Medical Examiner

Medical Certification: To

Baltimore, Maryland 21215-0020

with the Meryland

Director

Funeral

Be Completed by

State Registrar

31. Date filed (Month, Dey, Year)

JUN 2 3 1999

29b. Signature end July of certific

9701- VEIRS DRIVE, ROCKVILLE, MD. 32 Registrar's Signeture

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print)

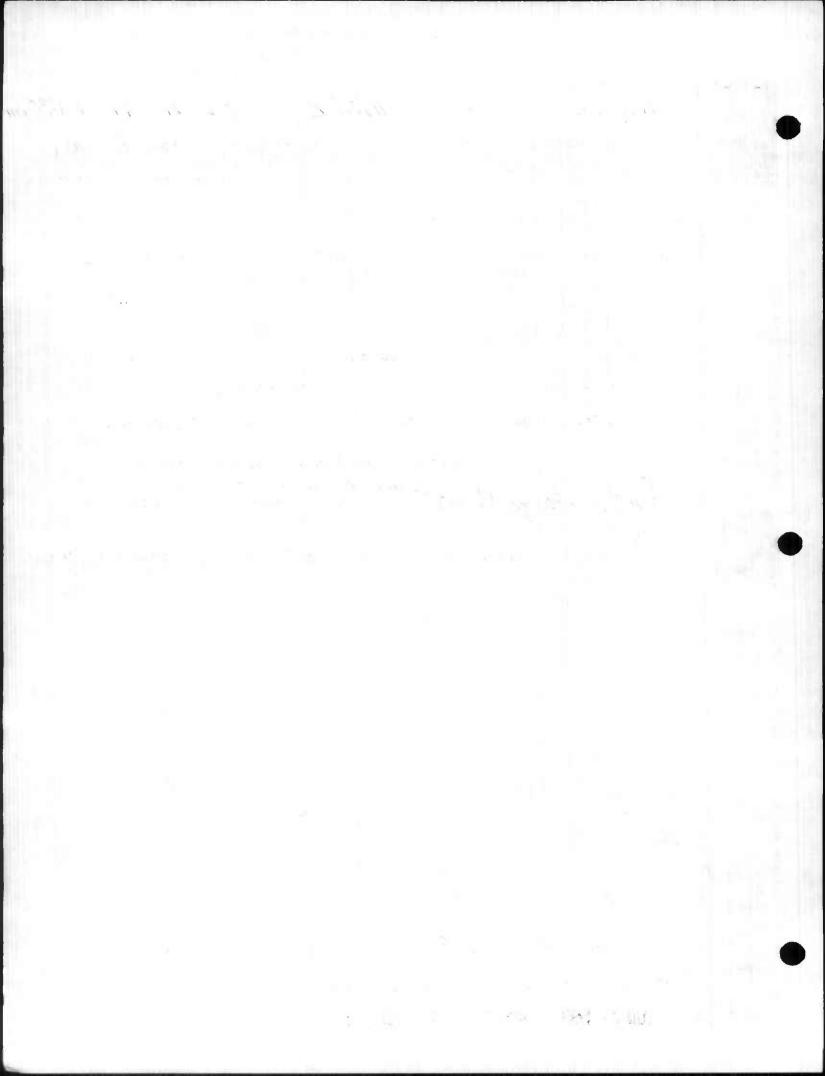
29c. License number

29d. Dete signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 99 2 | 579

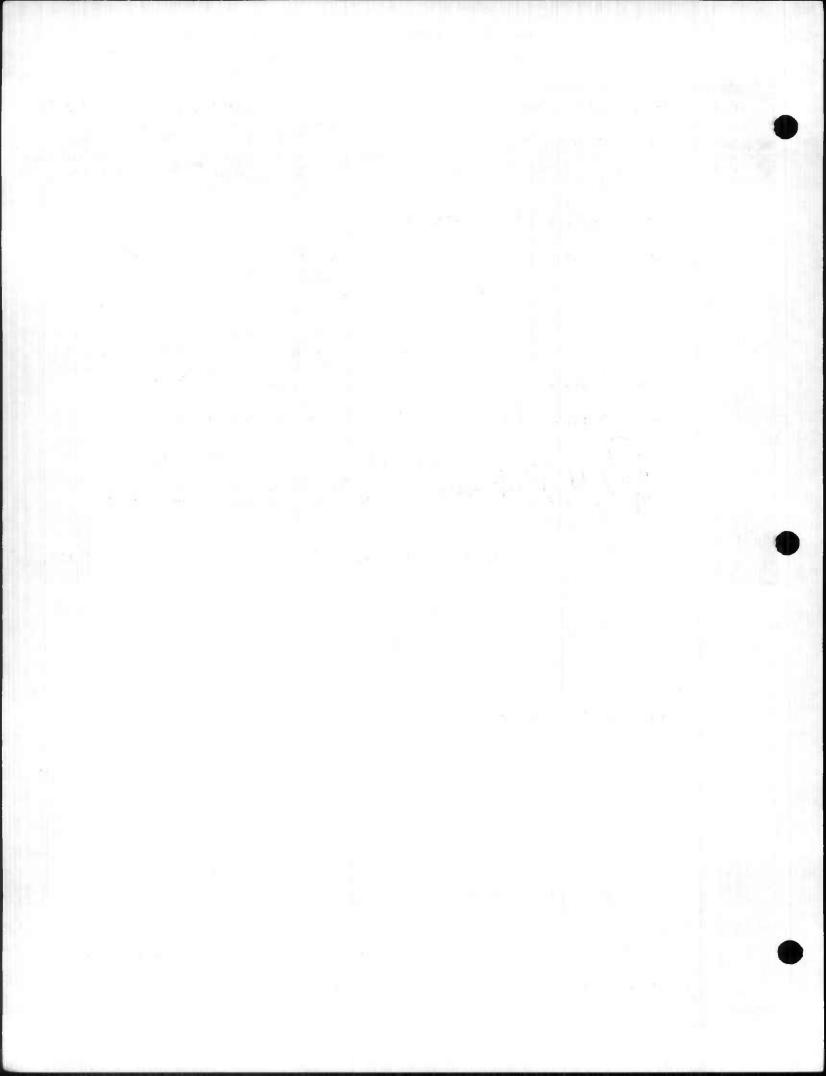
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State of Maryland / Department of Health and Mental Hygiene 99 2 | 580

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	the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours effer death. The Function and an in 24 hours effer death. The Function and an in 24 hours effer death. The Function and an interportant: If ten 27 is marked other than "natural," or items 23a or 28e4 show any inportant: If ten 27 is marked other than "natural," or items 23a or 28e4 show any input or other traumatic event, the Medical Examiner any injury or other traumatic event, the Medical Examiner any injury or other traumatic event, the Medical Examiner and insportant of the burner in the function and any injury or other traumatic event, the Medical Examiner and insportant of the burner in the function and any injury or other traumatic event, the Medical Examiner and insportant of the properties of the principal and injury or other traumatic event, the Medical Examiner and insportant of the properties of the principal and injury or other traumatic event, the Medical Examiner and insportant of the principal and injury or other traumatic event, the Medical Examiner and insportant of the principal and injury or other traumatic event, the Medical Examiner and insportant of the principal and injury or other traumatic event, the Medical Examiner and insportant of the principal and injury or other traumatic event, the Medical Examiner and insportant or the principal and injury or other traumatic event, the Medical Examiner and insportant or the principal and injury or other traumatic event, the Medical Examiner and insportant or the principal and injury or other traumatic event, the Medical Examiner and injury or other traumatic event, the Medical Examiner and injury or other traumatic event, the Medical Examiner and injury or other traumatic event, the Medical Examiner and injury or the principal and injury or the principal and injury or the principal and injury or the principal and injury or the principal and injury or the principal and injury or the principal and injury or the principal and injury or the p	4a. Fecility Neme (If not institution, ghd 11595 Acton Lane	re street end nur	nber)					dorf	tion of Deeth	4c. County Char	of Death les			
			5. Sociel Security Number 6. S 220-28-7463 Usuel Residence of Decedent	Sex 10ĂM2□F	7. Age (In yrs. les	Yrs.	If Under 1	Year Deys	If Undar 2	4 Hrs. 8.	Data of Bird (Month, Da eD 6	, 1935	9. Births Mary	Place (State or F	oreig
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h wish sh	23e or 21		10e. Street end Number 11595 Acton Lane				10f. Zip Co		20601			10g. Citizen of Whet Country? USA			
O.Z.O.	rai', or items	by	11. Meritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Dece Armed For 1 Yes If Yes, Giv Yeer or De	2 X No e		13. Wes Decedent of Hispanic Origin? (S if Yes, specify Cuben, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:			in? (Specif Puerto Ric	y Yes or No an, etc.)	14. Rad Ble Specif	ck, White,	can Indien, etc.	
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	/Medical		23a. Pert1. Enter the disaase, or complications that caused tha death. Do not enter the moda of dying, such as cardiec or respiretory errest, shock, or heart failura. List only one cause on each line. Immediate Ceusa (Finel disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Dua to (or es e consequence of):									Approximele Interval Betwe Onset end Dec	eth		
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he Hoenit	in 24 hour he Funeri pletely fill	edical	29a. Certifier 1 A Cartifying Pi (Check only one) 1 Medical Example 1 Medical Examp	nysician: To the miner: On tha be end menr	sls of axaminetio	edga, daeth n and/or inv	occurred et restigation, In	the tim	na, data end pinlon, daath	pleca, end occurred	d due to the et the time,	cause(s) and m dete end plece,	annar as : and due t	stated. o the cause(s)	
F	To the com	×	29b. Signeture end titla of certifier		gam	u. (D		e number 3	3		JUNE 2			
	0		30. Name and eddrass of person who YAHIA M. TAGOURI,	MD., ST	. MARY'S	HOSE	-	LE	ONARDI	ΓOWΝ,	MD				
	Sta Regist		31. Date filed (Month, Dey, Year)		egistrar's Signetu	A.	do	n.c	1						

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Frank John Mattia 1999 /Medical June 18 3:30 AM 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10111 Gardiner Avenue Silver Spring Montgomery If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1⊠M 2□F Yrs. 80 579-03-5033 Jan. 23, 1919 Washington, D.C. Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☒ No Director Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 10111 Gardiner Avenue Funeral 20902 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decadent Ever in U,S. Armed Forces? Raca - American Indien, Black, White, etc. 1 ☐ Never Married 2 X Married 1 X Yes 2 No If Yes, Give Year or Dates: WW II 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 8 Manager Grocery Seafood 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lorenzo Mattia Serafina Galasso 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1011 Gardiner Avenue Silver Spring, Maryland 20902 ace of Disposition (Name of Date 200. Location - City of Town, State <u>Anita Mattia</u> (wife) 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/23/99 S Dother (Specify) 4 Donation Arlington National Cemetery Arlington, Virginia 21. Signature of Fuperal Servica Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901

Approximate

Solution in the disease, or complications that cause on each the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) a. Stroke Days Due to (or as a consequence of): Examiner b. Atherosclerosis Years Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or es a consequença of): Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Probably 4 ☐ Unknown Diabetes Mellitus - Chronic by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy Venal Disease 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Realdenca 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 DNatural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide edicai 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 10 D 08188 June 18, 1999 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

311

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinating than the notified at

permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. If them 27 is merked other than "natural", or item any Injury or other traumatic event.

Physician /Medical

Examiner

requires that the death certificate be executed

The lew page 2 s

P.O. Box 68760,

Records,

Division of Vital

transit.

and

attending physician a for use as the buriel-

signed by the

this certificate

s after death.

I Director: After this od in by the funeral d

To the Hospital or Attanding Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral

director

Baltimore, Maryland 21215-0020

the Maryland

death

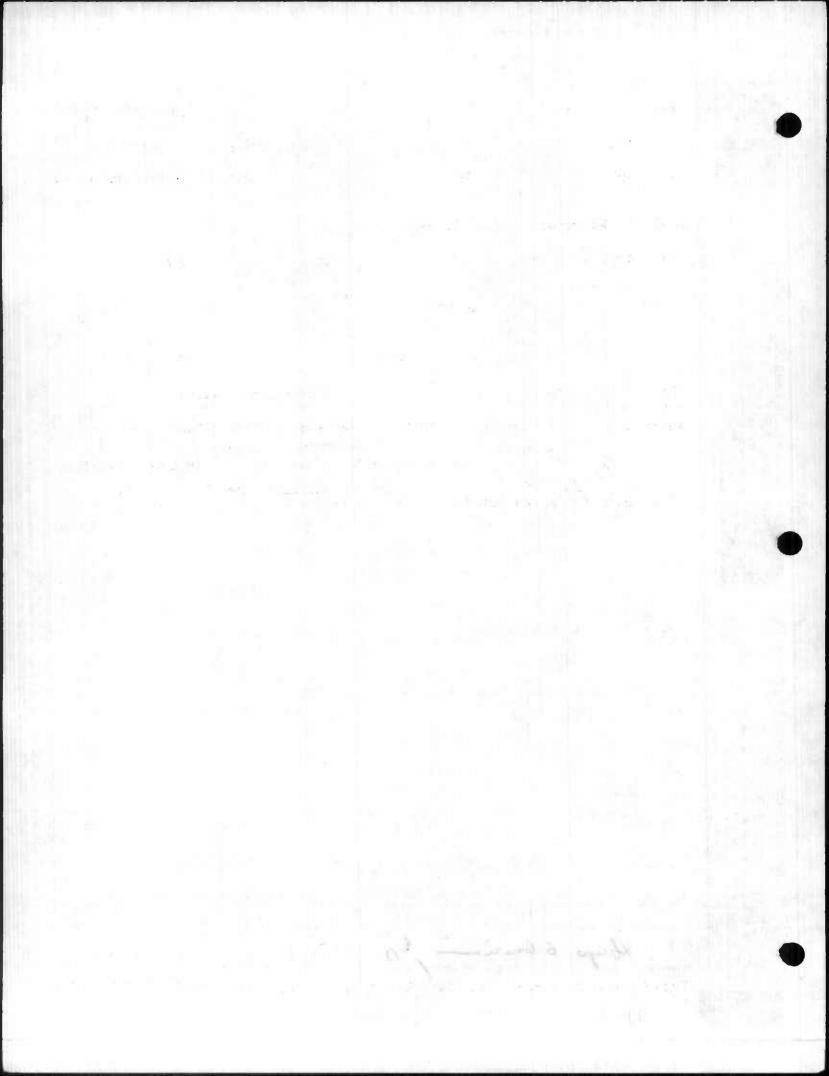
State Registrar

JUN 21 1999

31. Date filed (Month, Dey, Year)

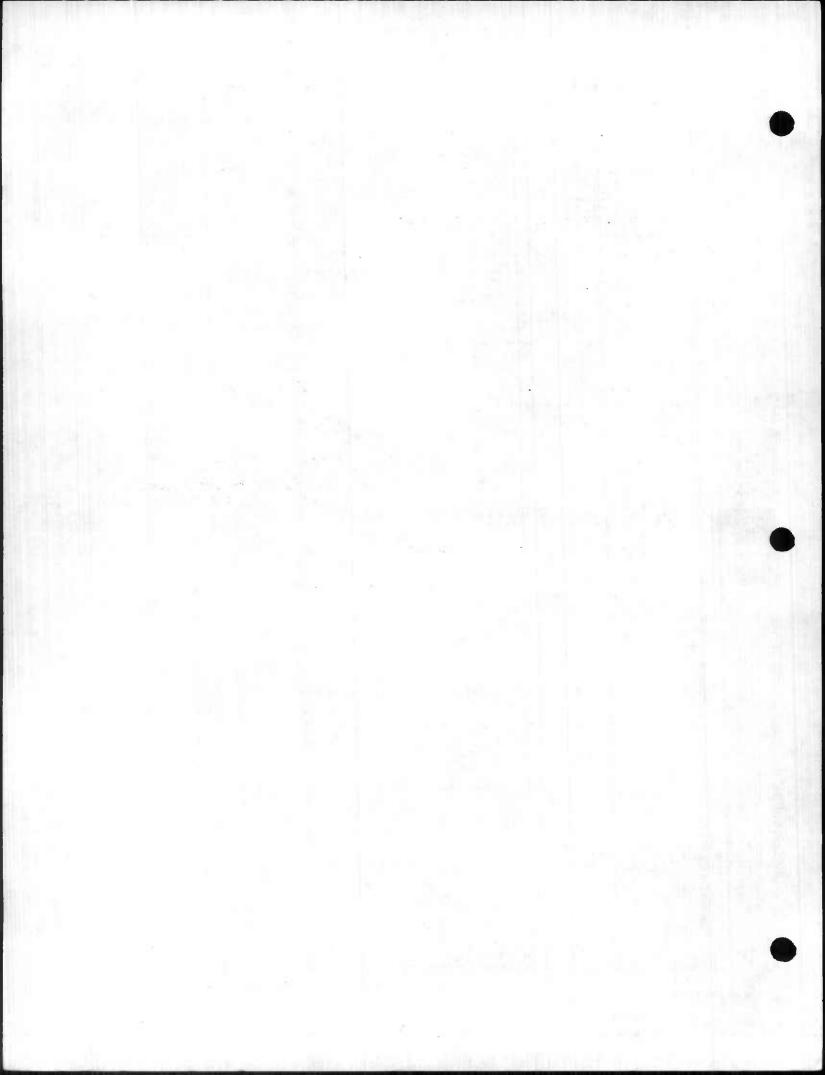
717 Pershing Drive Silver Spring, Maryland 20910-4321 Hugo G. Graziani, M.D. 32. Registrer's Signature

souls



State of Maryland / Department of Health and Mental Hygiene 9 9 2 | 5 8 2

			Ce	ertificate	of D	eath		Reg. No.	, ,	1002			
	1. Decedent's Nama (First, Middla, La	st)					2. Data of D Month	Death 3. Tima of Dea					
Physician /Medical	Thomas L. McK	evitt			Jı			21,	1999	10:00			
Examiner	4a Fscility Nama (If not Institution, giv	e street and number)			4b	City, Town, o	or Location of Dea	eath 4c. County of Death					
	10108 Big Rock Ro	ad			S	llver S	Spring	Montg	omerv				
Funeral Director	5. Social Security Number 6. S		n yrs. last birthday Yrs.	If Under 1 Year If Under 24 Hrs. 8, Data of Birth 9, Births					9. Birthp	lace (Stata or For			
	Usual Residence of Decedent 10a. State 10b. County		c. City, Town or L	ocetion	1		1200 30	,,1310		Od. Inside City Lir			
fled at	Maryland Montgome		ilver Sp							1 ☐ Yas 2 ⊊			
re 23e or 28e-f show r.matthe notfled at neral Director	10e. Street and Number 10108 Big Rock Ro	ad		101. Zip 0				10g. Citizen of USA	What Coun	try?			
r, or line	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1≜ Yes 2 □ No If Yes, Give Year or Dates: W			ent of Hisp ly Cuban,	t of Hispanic Origin? (Specify Yes or No- Cuban, Mexican, Puerto Rican, etc.) No Specify:			o- 14. Race - American Indian, Black, White, atc. Specify: White				
## to	15. Decedent'a Ed (Specify only highest gra	lucation ide completed)	16a. Deci (Giv	edent's Usual e kind of work DO NOT use	Occupati done du	on ring most of w	rorking	16b. Kind of B	usiness/Inc	lustry			
ther then ort, the Me	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Law		, , , , , , , , , , , , , , , , , , , ,			Law					
工芸芸 の	17. Father's Name (First, Middla, Last)				1	8. Mother's N	ama (First, Middle	, Maiden Sumar	na)				
Mental arkad can affic ev	Thomas Leonard Mc	Kevitt				Theres	a Nolan						
DEE	19a. Informant's Name/Ralationship (Type, Print)	19b. Mai	ling Address ((Street an	d Number or	Rural Routa Numi	ber, City or Town	Stata, Zip	Code)			
asith and Men n 27 is marks ar traumatic To	Dorothy D. McKevi	tt / Wife	1010	B Big F	Rock	Road,	Silver S	pring,	MD 20				
nert of He int: If Near iny or oth	20a. Mathod of Disposition 1 © Removal from State 4 © Donation 5 © Other (Specify) 20b. Place of Disposition (Name of cametery, crematory or other place) Gate of Heaven Cemetery 28,1999 Silver Spring,												
Depart Import any lej once.	21. Signature of Funaral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. W., Silver Spring, MD 209 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, intervel Between Onset end Dealth.												
nysician Medical xaminer	Immediata Cause (Final disaasa or condition rasulting in death) Electrolite imbalance 4wks Due to (or as a consequence of):												
<u> </u>			-										
physician and s the burial-transit edical Examiner	Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury	b. Irreversa	to (or es a conse		OI S	swallow	ing mech	anism	1	3months			
d by the attending physician and letached for use as the burial-transit Physician/Medical Examir	Cause (Disease or Injury that initiated events resulting in death) Last	c	to (or as a conse	quence of):									
d for	Part II. Other significant conditions o	ontribution to death but no	ot resulting in the	underlying cau	use niven	in Part t	23b. Did	tobecco use co	ntribute to	the cause of de			
		orninoning to could but it	A resulting in the	or conjung can	use gives					pably 4 Unk			
been s should							24a. Wa peri	s an autopsy ormed?	COL	are autopsy findir ailable prior to mpletion of cause death?			
ate has been signed by the page 2 should be detached.							1 🗆	Yes 2⊠No	10	Yes 2 No			
certificate rector, pa	25. Was casa refarred to medicat					26. Place of D	eath (Check only	one)					
eral di	axaminar? 1 Yes No 27. Manner of Death 1 Netural 5 Pending	Hospital: 1 Inpatient 28a. Data of Injury (Month, Day Ye	2 ER/Outpation 28b. Time Injury		c. Injury a Work?	4 LI Nursing	Home 5 🗵 Res 28d. Describe	idence 6 Ott		v)			
within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral Medical Certification:	2 Accident invastigation 3 Suicide 6 Could not be 4 Homicide determined		At homa, farm, a specify)			~ ~ ~ ~ ~ ~ ~	28f. Location City or To	(Street and Num own, Stata)	ber or Rura	l Routa Number,			
he Funera pletely fille edical C		ysician: To the best of my liner: On the basis of exa											
ompl	29b. Signatura end title of burtiller	//	111	29c.	License	number		29d. Date signe	ed (Month,	Day, Year)			
10	D 02338 June 22, 1999									9			
10	30. Name and addrass of person who				7.7		MD 00	002					
	Richard P. DELANE			Ave.,S	ilve	r Spri	ng,MD 20	902					
State Registrar	31. Data filed (Month, Day, Year)	32. Registrar's	Signature &	hor	1/21								



Amend :	#19a	, 6/29/99,BMW,Montq	State of Maryland		tment of ificate of			w	21583
		Decedent's Neme (First, Middle, Last)	.00.	Oort	modito or	Doutin	2. Dete of Dea	Reg. No. ath Dey	3. Tima ot Deeth
14.	ician dical niner	MARILYN L. MO	DLENOF treet and number)			4b. City, Town, or L	JUNE 2	2, 1999	9:40 AM
Funer Directe		HEBREW HOME OF GE 5. Sociel Security Number 5.79–48–1596	REATER WASHING 7. Age (In yrs. le	st birthday)	If Under 1 Yea Months Deys		8. Dete of Birt (Month, De)		MERY 9. Birthplace (State or Foreign Country) WASHINGTON, D
•		Usual Residence of Decedent 10e. Stale 10b. County MARYLAND MONTGOME	10c. City,	Town or Loca	stion SPRING		AUGUST	20,1932	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
3 24	i Director	10e. Street end Number 8 AQUARIUS COURT			10f. Zip Code			10g. Citizen of W	
20 after dea or items	by Funeral		2. Wes Decedent Ever in U,S Armed Forces? 1 ☐ Yes ②☐ No If Yes, Give Yeer or Detes:	If Y	es Decedent of	Hispanic Origin? (Sp ben, Mexican, Puerto	ecify Yes or No	14. Rece Black	- American Indian, k, White, etc.
15 n 72 n 22 n 22 n 32 n 3	Completed	15. Decedent's Educ (Specify only highest grade	etion completed) College (1-4or 5+)	16e. Decede (Give ki life. DC	nt's Usuel Occu nd of work done O NOT use retire	pation a during most of work ad)	ing	siness/Industry	
Maryland 2121 d 2 should be filed within th and Mentel Hygiens 7 Is marked other than " traumatic event, the Max	To Be Com	12 17. Fether's Neme (First, Middle, Last) (UNKNOWN) GOLDST		SECR	ETARY	18. Mother's Nem			CORPORATION (OR)
other	Ţ	19a. Intormant's Neme/Relationship (Type ALBERT 0. SOLDED CO. Method of Disposition 1 X Buriel 2 Cremetion 3 Re 4 Donetion 5 Other (Specify)	(HUSBAND) (HUSBAND) 20b. Ple	8 AQU ce of Disposi metery, crema	ARIUS C	et and Number or Rui	ER SPRI	NG, MARY 20c. Location	State, Zip Code) LAND 20906 City or Town, Stete MARYLAND
Baltimo permit. Pege Depertment of Important: If any Injury or	DOCC.	21. Signeture of Funeral Service Licenser	Otottleme	22. DA	Name end Addi NZANSKY 70 ROCK	ress of Fecility Y-GOLDBERG	MEMORI.	AL CHAPE	LS, INC.
Physicia /Medica Examine	al er	23e. Pert1. Enter the disease, or complic shock, or heart feilure. List only one Immediate Ceuse (Finel disease or condition resulting in death)	PNEUME Due to (or						Interval Between Onset and Deeth
Box 68760, sath certificate be executed attending physician and for use as the buriel-trensit	Medical Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest	HYPERT	es e consequ	S 10 /	,	ISEAS	E	YEARS
. 9 0 0	nysiclan	Pert II. Other significant conditions cont	ributing to death but not resul	ting In the und	lerlying ceuse g	riven In Pert i.		tobacco use cor Yes 2 □ No	atribute to the cause of death
cords, v requires to been signs should be	Completed by Physician/M	PANHYPOPIN					24e. Wes	en eutopsy ormed?	24b. Were autopsy findings evalleble prior to completion of ceuse of deeth?
= F # B	Ве Сош	25. Wes case reterred to medical exeminer?				28. Place of Dee	1 ☐ 1		1 ☐ Yes 2 ☐ No
Of Ohya	2	27. Menner of Deeth 1 Neturel 5 Pending 2 Accident Investigation		R/Outpetient 28b. Time of Injury	28c. Inj			dence 6 Other	
Division al or Attending s effer death. il Director: Afte	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, tarm, stree	et, factory, office	Э	28f. Location (: City or Tox		er or Rurel Route Number,
Division To the Hospital or Attending I within 24 hours efter death To the Funeral Director: After completely filled in by the funer	edical (clen: To the best of my know er: On the basis of exeminetic end manner stated.						
To the To the comple	M	29b. Signeture end jitle of certifier	Lopson	MD	29c. Licer	0588	-5		(Month, Day, Year)
		30. Neme end eddress of person who con	npleted cause of deeth (Item)	23e) (Type, P	rint) DNTR				ILLE, MD

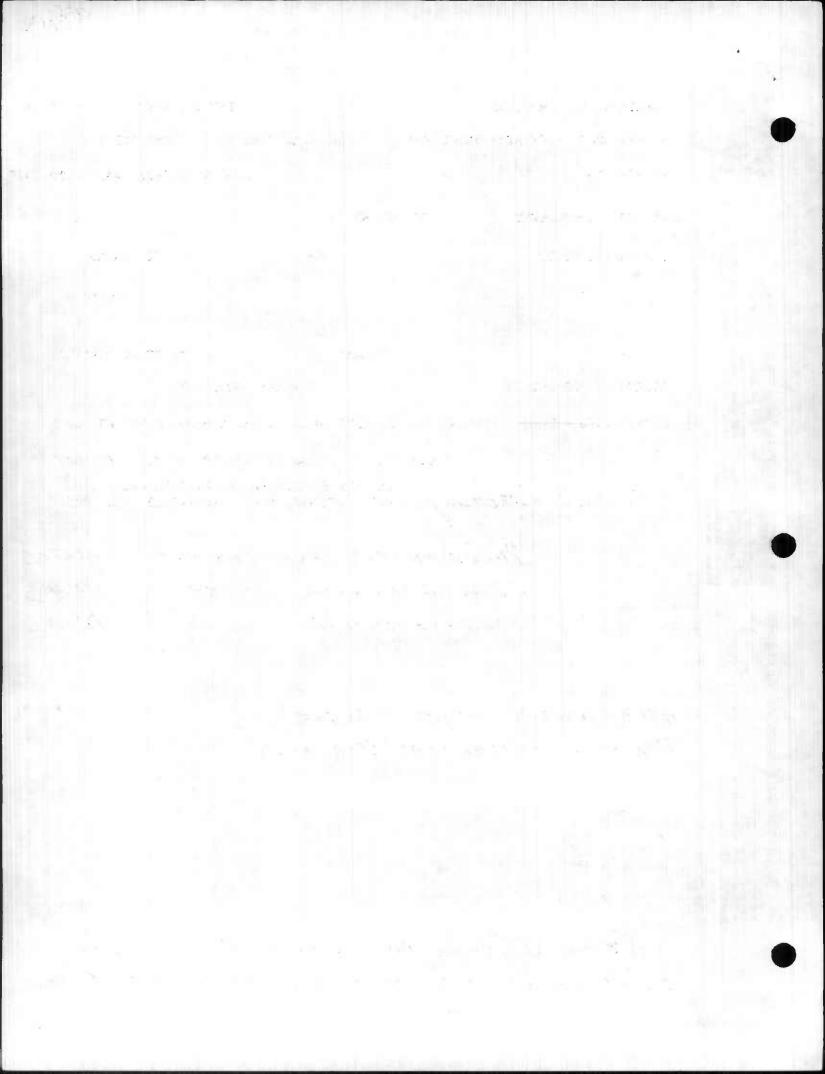
State Registrar

STEVEN LIPSON

31. Dete filed (Month, Day, Year)

JUN 2 5 1999

32.



Box 68760. P.O. 1 Division of Vital Records,

or Attending Physicien: After this death. efter death I in by t To the Hospital o within 24 hours of To the Funeral DI

> State Registra

Medical

31. Date filed (Month, Day, Year) JUN 25 1999

6 Could not be determined

2 Accident

4 Homicide

(Check only

29b. Signature end title of certifier

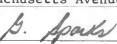
3 Suicide

29a. Certifier



30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

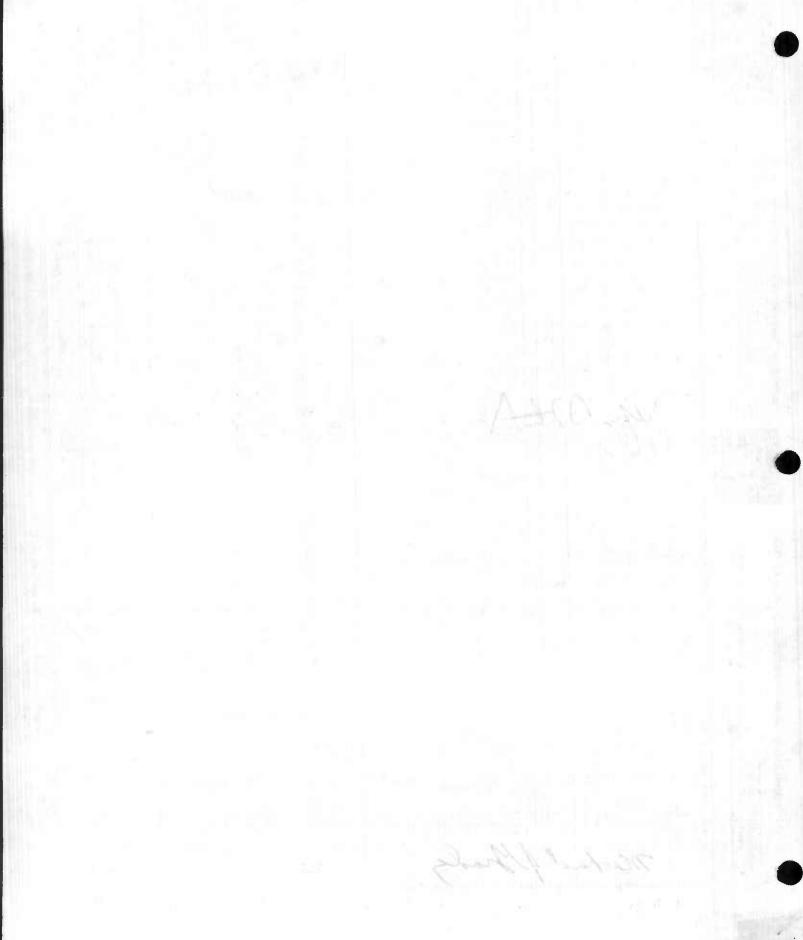
29c. License number

D 38781

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Dete signed (Month, Day, Year)

June 22, 1999



State of Maryland / Department of Health and Mental Hygiene O o

					Sia	ie oi ivi	iai yiai iu		ertificate o				Reg. No.	9 2	158	5
ı	Physician	ANT		SHAUGH		M	TURRAY					2. Date of De Month JUNE	Day 18, 199	Yaer	3. Time of C	
	/Medica Examine	4n En	cility Name (i	f not institution,		and number)			4b. City, To	own, or Lo	cation of Deat		nty of Death		
			SHAD	Y GROV	E ADV	JENTI	ST HO	SPI	TAL	ROC	CKVI	LLE	MON	TGOM:	ERY	
	Funeral Director	10	ial Security N 3-20-2	435	6. Sex 1 M 2		ge (In yrs. les	t birthdey Yrs.	Months Day		r 24 Hrs. Min.	8. Data of Bir (Month, De			plece (State or ntry) York	Foreign
	yland	10a. S	Residence of tate	10b. County			10c. City, 7	own or I	Location						10d. Inside City	
	Mar Mar	Ma	ryland	Montg	omery		G	erma	ntown						1 ☐ Yas 2	X No
	or 28	10e. S	treet and Nur						10f. Zip Code)			10g. Citizen o	1 What Cou	ntry?	
	23a 23a	19	901 St	oney Po	int Wa	ıy			208					d Sta		
21215-0020	72 hours after death with the Maryland natural, or items 23s or 28s-1 show deal Examiner must be notified at	30		ed 2 Marri	Am 1 [s Decedant ned Forces' Yes 2X 'es, Give ar or Dates:	No	13	. Was Decedant of If Yas, specify Co			ecify Yes or No Rican, atc.)	Spec	eca - America lack, White, city: whi	etc.	
0	natural',	3	/0	15. Decedent	s Education	d- 4 a all		16e. Dec	edent's Usuel Occ	cupation	at of worki	ína	16b. Kind of	Businass/In	idustry	
215	E 19	Elar		ify only highes ndary (0-12)	1	lege (1-4or	5+)	life.	edent's Usuel Occ re kind of work dor DO NOT use ret	ne auring mo: ired)	St of Worki	ng				
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pu	Mental Hygiene. arked other than stic event, the M	17. Fa		(First, Middla, L	.ast)					18. Moth	ner's Name	(First, Middla	, Maiden Sum	eme)		
yla	should by and Menta			James		lughne					nna		Rehr			
Maryland	2 sho			me/Relationsh					iling Addrass (Stre							
	es 1 end 2 should be filed of Health and Mental Hyg i Nem 27 is marked other r other traumatic event,	-	auneen lethod of Dis	Mirand	a, Da	lughte			9 Emeral		ve, G	ermanto	own, MD			
Baltimore,	Pages nent of mrt: W i	1	Burial P	Cremation 5 Othar (Sp		from State		opo]	position (Neme of emetory or other p litan Cre	matory	У	une 19 1999			Virgin	ia
Bal	permit. Pa Departmen Important: any Injury	21. Si	4	neral Service	icensee	Les	, .		22. Name and Add				ol Fune ithersb			377
		23a. l			complications	that ceuse se on each l	d tha daath. line.	Do not a	nter tha mode of o	lying, such as	s cerdiac o	or respiratory a	rrast,		Approximate intervel Between	een
50	Physician		/	O				•	5.1	- 1-					Onsai and De	
	/Medical Examiner	disaa	diate Cause (se or condition ng in death)	Final n	a	D€	POTI	C	210	CK				1	1/0	AUS
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68	35 CD 00 -	resulti	ng in death)	ast			Due to (or as	e conse	equ e nce or):					1		
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	at the death certification of the attending eteched for use to be bounded for the physical and the second of the s	Part II.	Other signif	cant condition	ns contributin	g to death l	but not rasultii	ng in the	undarlying cause	given In Part	ı.	23b. Dld	tobacco use	contributa	to the cause of	death?
P.0	ad by the deteched		Da	ch 1	Au.	100						10	Yes 2 No	3 Pro	obably 4 U	Inknown
	as the igned be de		CON	MUX	niu	KE	•									
Records,	The law requires that the death cert set has been signed by the attending page 2 should be deteched for use page 2 should by Dhyst clan Manacician Manacican Ma		Van	MA	TORU	1FA	7LUK	E		/		24a. Was	en eutopay ormed?	al Cd	lare autopsy fin vailable prior to empletion of ca	
3ec	hes to	1	10	W SECTION		,	. 000			/					death?	
a	cete he		CO	NEB	RA	2/1	VIA	Re	XION	/		10	Yes 2 No	1	☐ Yas 2☐ N	10
Vital	Physician: The this certificate ral director, pag) ex	aminer?	red to medical	Hospital					Other:		h (Check only				
of	his his		Yes 2 Inper of Deat	No		Date of Inj		l/Outpati	elli 30 DOV	7 🗆 🗆		me 5 Resi			ify)	
	ga iga	\$	Natural	5 Pending		(Month, De	by Year)	Injury	V	Vork? ☐ Yes 2☐		200. Describe	now injury coo	01100		
S	deati ctor: y the	3[Accident Suicide	6 Could n	ot be	Place of in	iury - At homi	a. farm. s	straat, factory, offic			28f. Location (Street and Nu	mber or Rui	al Routa Numb	er,
Division	tal or Attending P is after death. al Director: After the funeration by the funeration.	4 [Homicide	determi	100	building, a	tc. (Specify)	D, 141111, (maat, ractory, com			City or To	wn, State)			
			Certifiar Check only						ath occurred at the							
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	Within To the	29b. S	ignatura and	title of certile	\leq	_			29c. Lice	ense number	01	-	29d. Date sig	ned (Month,	1000	
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		IV	lauk	BIN	to complete	b cause of	death (Itam)	lea	Ica C	ente	V D	rko	Chul	le,1	W) Zo	850
	State Registrar			n, Dey, Yeer) N 2 2 19	399	32. Degist	rar's Signatur	· 6.	Sport	2				(

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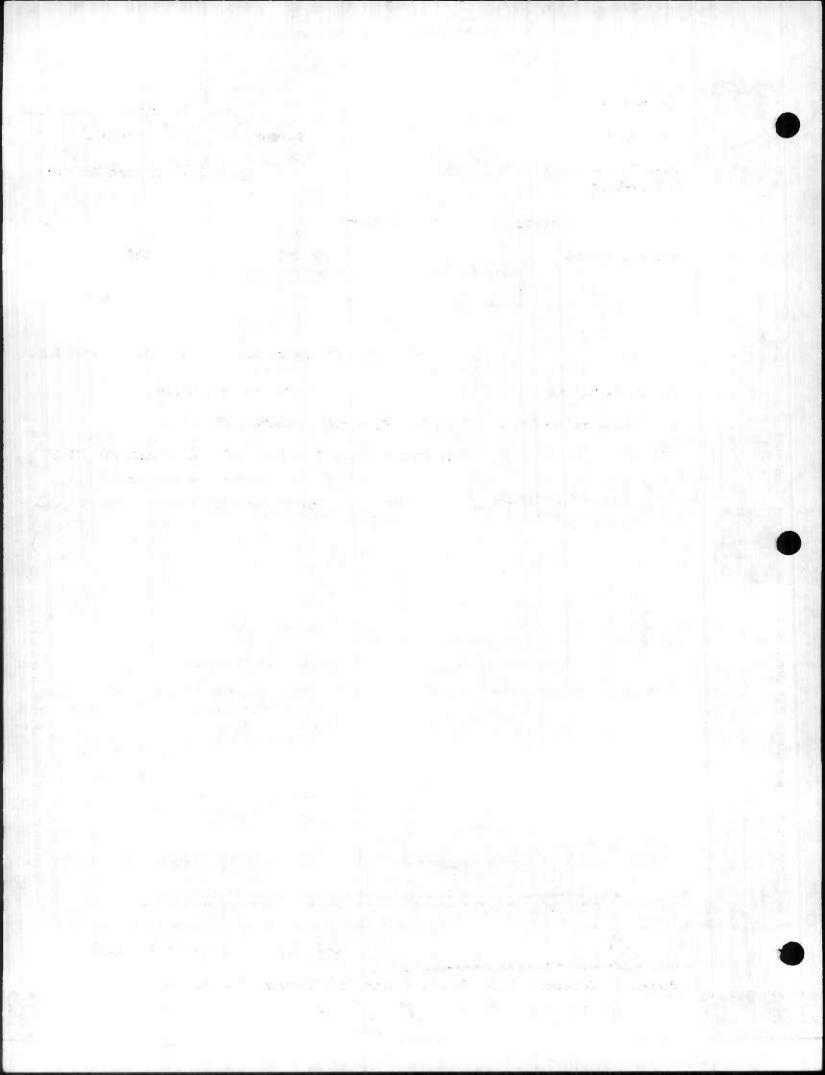
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Data of Death 3. Time f Lee th 1. Decedent's Name (First, Middla, Last) 1999 **Physician** JUNE 11, 5:00 AM SHIRLEY LYNCH MULLEN * /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner SWANTON GARRETT 659 WHITE OAK DRIVE 8. Date of Birth (Month, Day, Year) APR 22, 19 If Under 1 Year II Undar 24 Hrs. 5. Social Security Number Birthplace (Stata or Foraign Country) 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 F Months Days Hours Yrs. 208-26-0361 PA 66 Director Usual Residence of Dacedani with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinal must be notified at 1 ☐ Yas 2 NO GARRETT SWANTON Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 659 WHITE OAK DRIVE 21561 IISA Funerai death 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 should be filled within 72 hours after a end Mental Hygiena. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) HOMEMAKER OWN HOME 12 18. Mother's Name (First, Middla, Maidan Sumama) 17. Father's Name (First, Middla, Last) SARAH LYNCH CLEM 10 Department of Health and 2 sh. Department of Health and Important: If item 27 is mai any injury or other traumet once. 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) SWANTON, MD 21561 HERMAN MULLEN - HUSBAND 659 WHITE OAK DRIVE altimore, 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 Cremation 3 Ramoval from State 6/15/99 ELIZABETH, PA ROUND HILL CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 Part1. Entar the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Betw Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting In death) /Medical SUDDEN CARDIAC DEATH IMMEDIATE Examiner Due to (or es a consequenca of) Examiner 2 YEARS CARDIOMYOPATHY icien end buriel-transit certificate be executed Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events Due to (or as a consequence of): Box 68760. attending physicien for use es the burie Physician/Medicai Due to (or as a consequence of): resulting in death) Last 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. the 1 Yas 2 No 3 Probably 4 Unknown signed by ATRIAL FIBRILLIATION ð Records, 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peen DIABETES MELLITUS completion of cause of death? certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 ☐ Nursing Home 5 Hestdence 6 ☐ Other (Specify) To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28d. Describe how Injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation or Attending 1 Netural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not ba determined 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Spacify) 4 ☐ Homicide 24 hours a Hospital 1E Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifie edicai completely (Check only one) To the To the F 29b. Signature and life of cortille 29c. License number 29d. Data signed (Month, Day, Year) JUNE 12, 1999 D23979 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 311 N. FOURTH ST. ROBERT A. GORALSKI, M.D. OAKLAND, MD 21550 31. Date filed (Month, Day, Year) 32. Registrar's Signeture boute Registrar JUN 14 1999

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Ray Miller 1999 1:15 A.M. June 27 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner McHenry Garrett 590 Hoyes Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year)
April 27,1916 West Virginia 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2□ F Days 213-12-9134 83 Yrs. Director Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location worde 10d. inside City Limits notified at Director 1 ☐ Yes 2 No 288-1 McHenry MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23e or 3 filed within 72 hours after death with 590 Hoyes Road 21541 USA Funeral items : Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 11. Maritel Status 12. Was Decedent Ever In U.S. Armed Forces? 14. Rece - American Indian, Black, White, etc. the Medical Examiner 1 X Yes 2 No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 X Married 21215-0020 9 1 ☐ Yes 🏋 No Specify: by Specify: White 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working el Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 12 New Projects Inspector MD State Highway Adm. Baltimore, Maryland 17. Father's Neme (First, Middle, Last) permit. Peges 1 and 2 should be filk Deportment of Health and Mentel Hy important: If Item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) Be Howard M. Miller Minnie Mae Broadwater 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) D. Blanche Miller/Wife 590 Hoyes Road, McHenry, MD 21541 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Church Cem., June 30, 1999 Accident, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

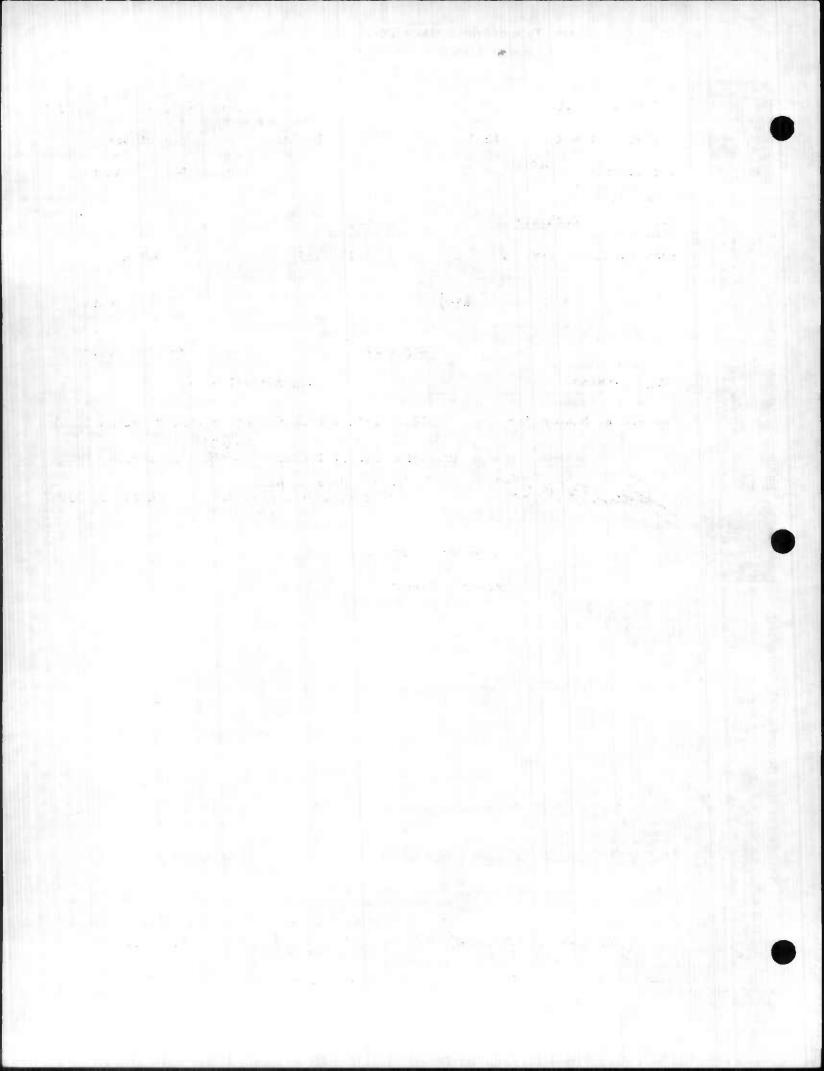
Approximation. 21536 Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final Myocardial Infarction Minutes disease or condition resulting in death) Examiner Due to (or as a consequence of): Coronary Artery Disease 1 Month The law requires that the death certificete be executed bunial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. ettending physician for use es the buna Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? Diabetes Type 2 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy certificate hes 1 ☐ Yes X☐ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home Residence 8 Other (Specify) 10 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 5 Pending investigation 1 Naturel To the Hospital or Attendir within 24 hours efter death.
To the Funeral Director: At completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 290. Signature and title of p 29c. License number 29d. Date signed (Month, Day, Year) D-23979 June 27, 1999 HIVA manu completed cause of death (Hem. 23a) (Type, Print) Robert A. Goralski, M.D., 311 N. Fourth St., Oakland, MD 32. Registrar's Signeture 31. Date filed (Month, Day, Year) State JUN 2 9 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene

				Certifica	ate of	Death		Reg. No.	23	215	88		
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aminer	4a Facility Nama (If not institution, give	a street and number)				4b. City, Town, or I	ocation of Deet	Deeth 4c. County of Death					
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al	5. Social Sacurity Number 6. S		(In yrs. last bir	thday) If Und Month		If Undar 24 Hrs. Hours Min.	8. Data of Bir (Month, Da	rth	9. Bi	rthplace (Sta	a or Foraign		
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o Be	Hugo Neumann					Stephani	e Tauss	kv					
F	19e. Informant's Name/Reletionship (Type Print)	19h	Mailing Addra	es (Straat	and Number or Ru		-	Town State	Zin Code)			
	The second secon												
	Ronald E. Neuman	in/son	20h Place of	Disposition (N	ngtor	n Blvd.,	Arlingt		Virgini cation - City o				
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	4 Donation 5 Other (Specify		Arling	ngton National Cem. 1999 Arlington, Va.									
any injury or other tr	21. Signature of Funarai Sarvice Licen	200				eral Home							
	2222 Wisconsin Ave., N.W., Washington, DC 20007												
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Cia	Part II. Other significant conditions or	ontributing to death but	not reculting in	the underlying	o cauca ai	uan in Bart I	23h Did	tobacco	uss contribu	te to the cau	se of death		
Physician/	Partin. Other significant conditions of	orithbuting to death but	not rasulting in	i tha dribanying	y causa yi	vali iii Fait i.		Yes 2		Probably 4			
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	30. Nama and address of person who	The state of the s											
	Uma Prasad, M.D.			nia Ave	., N.V	V.,Washin	gton,D.	C. 20	0037				
tate	31. Data filed (Month, Day, Year)	32. Registrar	's Signatura	1									
strar	11 IN 2. 9 1000	new	a M	Ani	20 1/2	/							



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 20, Hilda 1999 Katerina Nichols June 8:00 PM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12614 Millstream Drive Bowie Prince George's 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Deys Hours 1 □ M 2 🖾 F Months 134-16-9105 92 Director Oct.22, 1906 Germany Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Prince George's Bowie ne 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? GIA. 20715 United States 12614 Millstream Drive Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. than "natural", or iter the Medical Examiner filed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: White 1 Tyes 2 No Specify: þ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Tailor permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: if Ilem 27 is marked other any injury or other transmitted other.
Since 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) 98 Johan Bertrand Marie Lutze 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ingetraut John Wehling (Daughter) 12614 Millstream Drive, Bowie, Maryland 20715 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 6-21-99 Beltsville, Maryland Chesapeake Crematory 21. Signature of Funeral Service L 22. Name and Address of Fecility
Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) 1 week Sepsis Examiner Due to (or es a consequence of): Examiner 3 weeks Broncho pneumonia The lew requires that the deeth certificate be executed the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Bud Box 68760. physician Physician/Medical Due to (or es a consequence of) for use signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yea 2 No 3 Probably 4 Unknown Malnourished 2 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? Unspecified Endocrinopathy page 2 certificate hes 1 Yes 2 No 1 Yas 2 No or Attending Physicien: director. 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospitet: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 A Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) uneun 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation To the Hospital or Attending within 24 hours effer death.
To the Funeral Director: Afte completely filled in by the fun 1 Netural 1 Tyes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide t☑ Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D30111 June 21, 1999 201 Jone M. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary W. Jones, M.D. P.O. Box 385, Laurel, Maryland 20725

DHMH 16 Rev 6/95

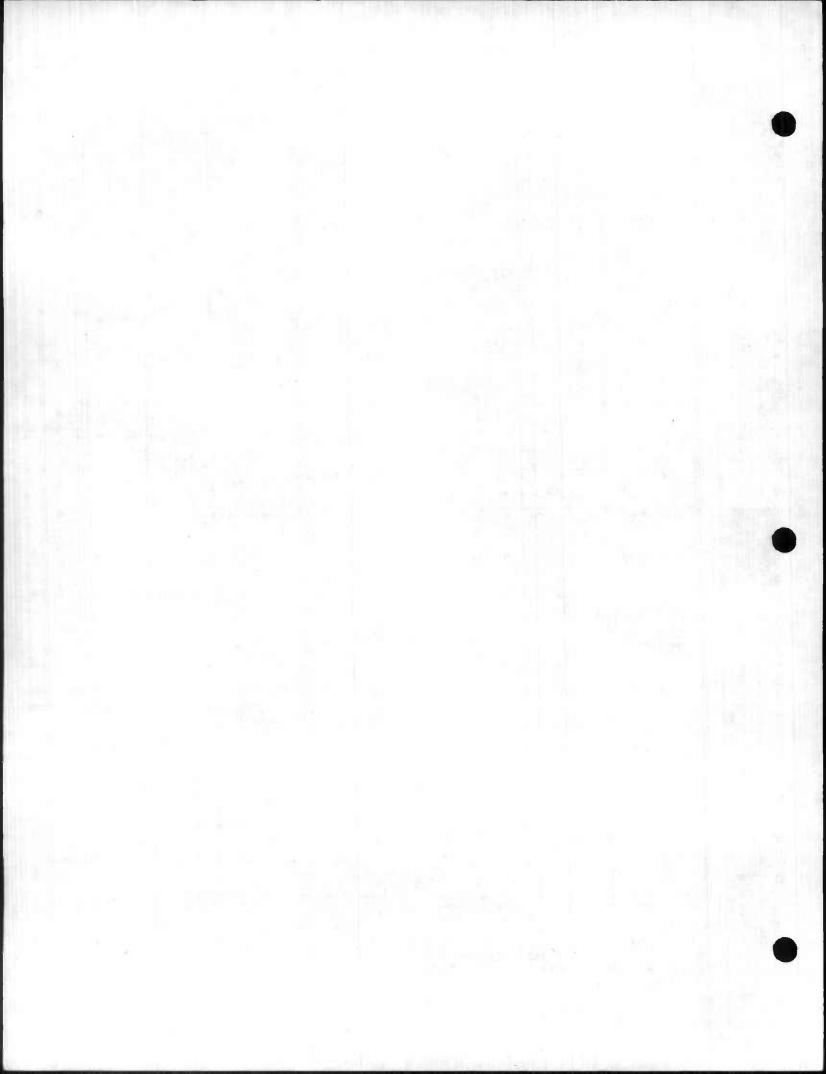
State

Registrar

31. Date filed (Month, Day, Year)

JUN 22 1999

32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death Month JUNE **Physician** 1999 RTCHARD **RALPH** NORRIS 21, 5:30 P.M. /Medical 4b. City. Town, or Location of Death 4a. Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner GOODWILL MENNONITE NURSING HOME GRANTSVILLE GARRETT If Under 24 Hrs. 6. Sax 1 M 2 ☐ F If Undar 1 Year 8. Deta of Birth Month, Day, Year) DEC 17, 1917 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days Hours 209-09-5790 81 Vre PA Director Usual Residence of Decedant permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other transmitter event, the Medical Exercises must be notified at 10a. Stata 10c. City, Town or Location 10d. Inside City Limits is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examinar must be notified at 1 Yas 2 No MD GARRETT GRANTSVILLE Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 48 KILLDEER LANE 21536 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ∑Yes 2 □ No If Yas, Giva Yaar or Datas: WW II Wes Dacedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuben, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Bleck, Whita, etc. 11. Maritel Stetus 1 ☐ Navar Marriad 2 ☒ Merried 1 ☐ Yas 2 X No Specify: Specify: ğ WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Spacify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b, Kind of Business/Industry College (1-4or 5+) Elamantary/Secondary (0-12) SALESMAN TIRE & RUBBER CO. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Meidan Sumame) Be RALPH NORRIS OLIVE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) JEAN E. NORRIS - WIFE 48 KILLDEER LANE GRANTSVILLE, MD 21536 20b. Placa of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cramation 3 ☐ Ramoval from State OMEGA CREMATORY 6/23/99 MORGANTOWN, WV 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Facility any ir P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 23a. Part1. Enter the disassa, or complications that caused the death. Do not antar the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Batween Onset and Death **Physician** Immadiata Causa (Final disaasa or condition rasulting in daath) /Medical metastatic adenocarcinoma to liver, unknown 6 wks Examiner primary Dua to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificete be executed and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of): the ettending physician a hed for use as the buriel-Division of Vital Records, P.O. Box 68760, that initiated avents Dua to (or as a consequence of): rasulting in death) Last Part II. Other significant conditione contributing to death but not rasulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? signed by the HISTORY of amyloidosis, ASCVD 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy lindings available prior to complation of cause of death? 24e. Was an autopsy performed? Completed Deen certificete has 1 Yas 2X) No 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was casa ralarred to medical axaminar? Be 26. Placa of Daath (Check only ona) Hospitel: Other: Winner Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral 28a. Data of Injury (Month, Day Yeer) 27. Mannar of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending invastigation 1 Natural 1 ☐ Yas 2 ☐ No 24 hours after death.

Funeral Director: A I Director: A 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, ferm, streat, factory, office building, atc. (Spacify) 4 Homicida Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

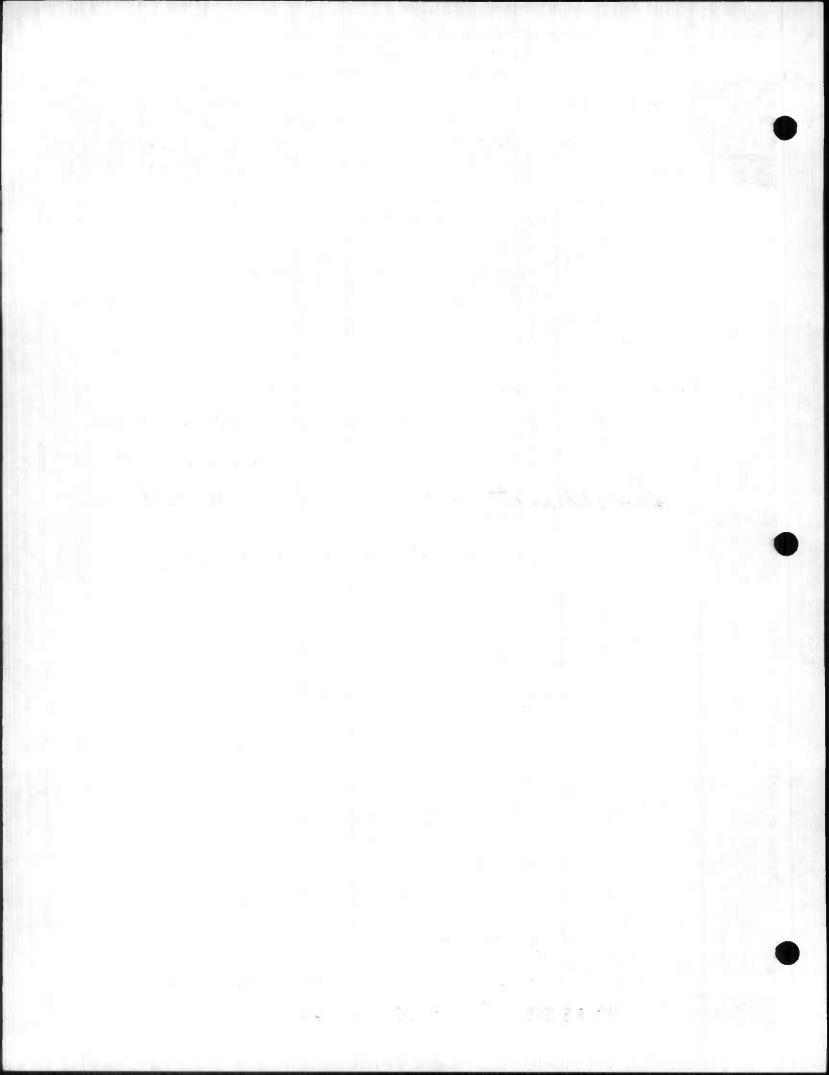
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| Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Cartifiar Medical (Check only one) within 2 29c. Licansa numbar 29d. Date signed (Month, Dey, Year) 29b. Signature a D30035 06-22-99 10+1VA 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) Donald R. Richter, M.D. 1533 Memorial Drive Oakland, MD 21550 31. Data filed (Month, Dey, Year) 32. Registrar's Signetura State

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Registrar

JUN 23 1999



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7 is marked other than "natural", or itsma 23a or traumatic avent, the Medical Examinar must be a

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Attending Pt death. scror: After the year funaral	27. Manner of Death 1 Naturel 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how In
Div afta	3 Suicide 6 Could not be determined	28e. Place of Injury · At I building, etc. (Spec	nome, farm, street, fo	ectory, office	28f. Location (Street City or Town, Sta
the Hospital				irred et the time, date and plac ation, in my opinion, death occ	
To the within 2 To the comple	29b. Signature and title of certified			29c. License number D304941	29d. E
(a) (b)	30. Name and address of person who K DESA/m Deokm	completed ceuse of death (Ite	m 23a) (Type, Print)	outh charles	st Balhi
State Registrar	31. Dete filed (Month, Day, Year) JUN 2 2 1999	32 Registrar's Sign	B.	only	
DHMH 16 Rev 6/95					

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 5:10 William D. Peterson JR JVNE 19901 13 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore University of manyland Medicine Bu Himore If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Number 6. Sex **Funeral** 3402 Months M 20 F Days 54 21, 1945 Director Usual Residence of Decedent 10b. County 10d. inside City Limits 10a. State 10c. City. Town or Location MD Prince Georges Takoma Park Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7051 Carroll Ave. Apt. 313 20912 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, 11. Mantel Status Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: Specify: Black þ 3 ☐ Widowed ♣ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Flementery/Secondery (0-12) College (1-4or 5+) 12th Business owner Grocery Store 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) Be William D. Peterson SR Martha Willis To 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) permit. Pages 1 and 2: Department of Haalth ar important: if item 27 is sny injury or other trsu once. 4017 Postgate Terrace, Silver Spring, MD 20906 Tonya D. Peterson 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State rlington Crematory rlington 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of acility James E. Vann Funeral Home, Inc 4804 Ga. Ave. N. W., Wash., D. C. 20011 Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart fallure. List only one cause on each line. Approximata Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) amins encophalepath Anoxic Due to (or es e consequenca of) Examiner failne 4 4-5 myestre hom L Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): 11 thouselenho Physician/Medical Due to (or es e consequence of) Vent dependent ecilu-e 4 mms 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Decabitus cleers þ 24b. Were autopsy findings available prior to opsy completion of cause of death? 2 PNO 1 ☐ Yes 2 ☐ No 6 Other (Specify) jury occurred and Number or Rural Route Number, ite) (s) end manner as stated. nd plece, and due to the cause(s) Date signed (Month, Day, Year) 113197

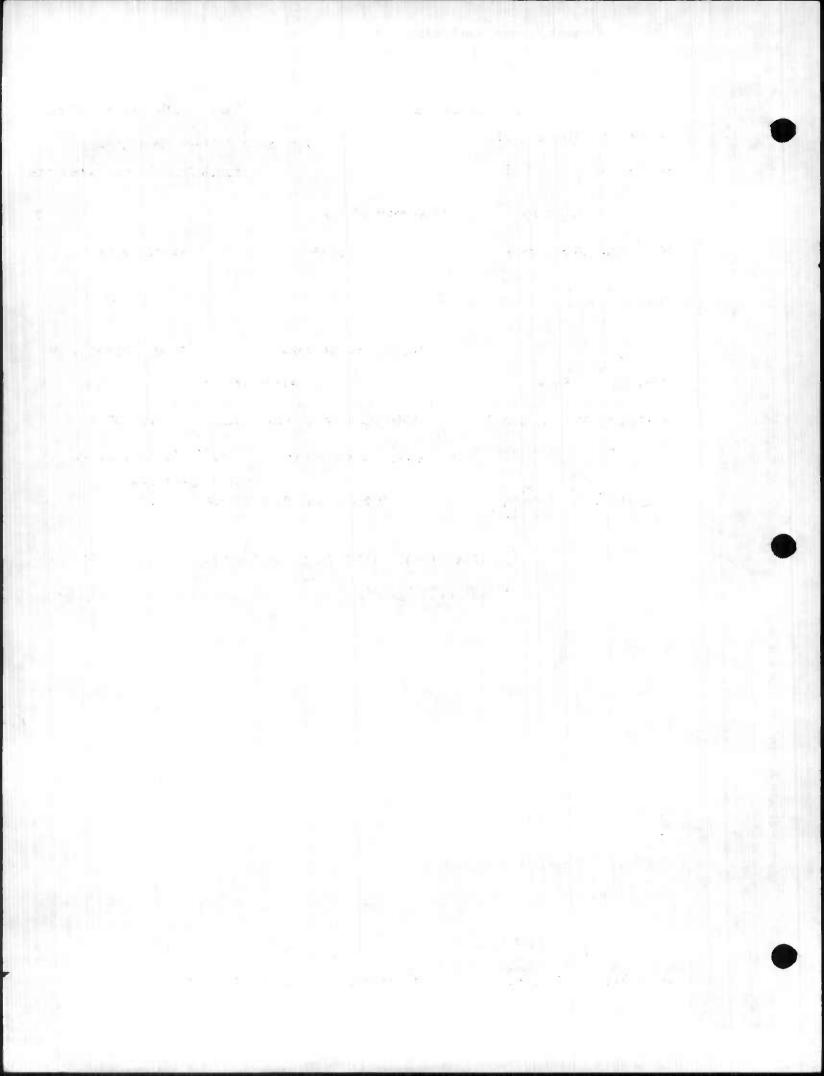
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

m12/230

State of Maryland / Department of Health and Mental Hygiene 9 9 2 1 5 9 2

			Oldio of Marylar		te of Death		eg. No.	41	592			
		1. Decedent's Neme (First, Middle, L	ast)			2. Data of Dea Month		Year	3. Tima of Death			
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	Funeral Director		Sex 7. Age (In yrs. 1	Yrs. If Und Months	er 1 Yeer If Under 24 Hrs.	8. Date of Birth (Month, Day March 2	9,1906	9. Birthpled Country Massa	chusetts			
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5-0	led within 72 ho ygiene. Ner than *natura nt, tre Medical Completed	15. Decedent's 8 (Specify only highest g	king	16b. Kind of Bu	isiness/Indus	atry						
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Man	0 5 p 5	18. Mother's Name (First, Middle, Last)										
9	工工五台	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cramation 3 4 ☐ Donation 5 ☐ Other (Spec	Ramoval from State	Place of Disposition (N cemetery, cremetory or tropolitan	other plece)	June 21,	20c. Location -					
Balti	permit. Peges Department of Important: If it any Injury or once.	21. Signature of Funeral Service Lice	**	22. Name	end Address of Facility De	Vol Fune						
2		Cuttes C. 1	Surg.		st Deer Park			-	. 20877			
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Division of Divisi	4 Homicide building, efc. (Specify) City or Town, State)												
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Partington Division Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	29b. Signature and	title of certifier	1135 (23,110)	4		29	c. Licens	se number		29d. Date sign	ed (Month,	Day, Year)	
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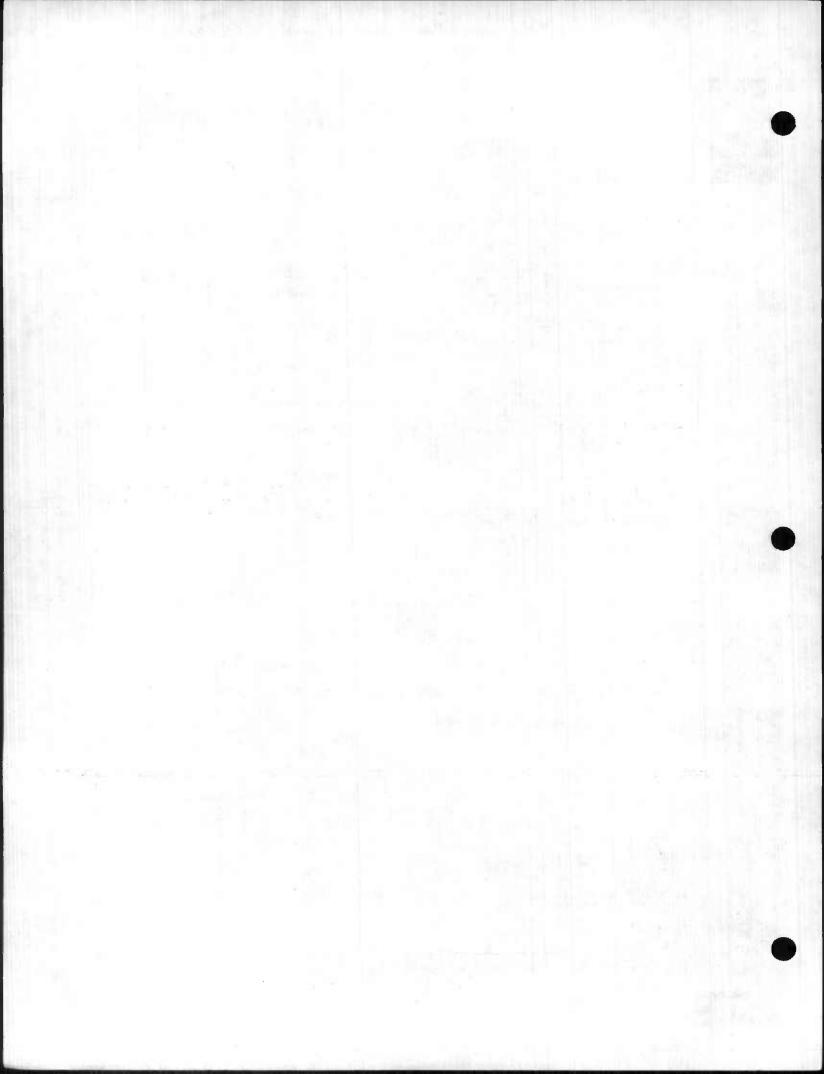
DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month Year **Physician** 4:26 pm Mildred Herndon Pierson 16, 1999 June /Medical 4a Facility Name (If not Institution, give street end number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring Mon If Under 24 Hrs 8. Date of Birth Min. (Month, Day, Year) Holy Cross Hospital Montgomery

9. Birthplace (Stata or Foreign

Country) If Under 1 Yaar 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Days Months 1 M 2 F 92 Yrs. 1907 Director Mar 4, Pennsylvania 446-05-4528 Usuel Residence of Deceden with the Manyland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 20 No Director Maryland Montgomery Silver Spring 10e Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral death 321 University Blvd. W, Apt 20901 USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puarto Rican, atc.) 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give 14. Race - American Indian, a filed within 72 hours after du Il Hygiene. other than "natural", or Item Bleck, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: P 3 → Widowed 4 □ Divorced Yeer or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed will Department of Health and Mental Hygiene Important: If item 27 le marked other tha eny injury or other traumatic event, Italia. 12 Clerk Clerical 17. Fathar's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Charles W. Jones Gertie R. Beck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 10809 Breewood Rd., Silver Spring, MD 20901 of Disposition (Name of T., Dete 1.9 20c. Location - City or Town, State Louise Herndon Ofano /Daughter 20a. Method of Disposition 20b. Plece of Disposition (Neme of cematary, crametory or other plece) Jun 18 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 1999 4 ☐ Donetion 5 ☐ Other (Specify) Alexandria, VA Metropolitan Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Francis J. Collins Funeral Home, Inc. 500 University Blvd. W, Silver Spring, MD 20901 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear fellure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediete Cause (Finel 48 hrs Ischemic bowel diseasa or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner Adhesions physician and s the burial-transit certificate be executed Sequentially list conditions, if eny, leeding to Immadiate cause. Enter Underlying Cause (Diseese or Injury that initieled events resulting In death) Last Due to (or as e consequence of): Box 68760 Physician/Medical Dua to (or as a consequence of): for use as 88 The law requires that the death detached 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed peeu page 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Division of Vital or Attending Physician: Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2⊠ No Certification: To 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury et Work? Affer 1 Netural 5 Pending i Director: Aft d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours of To the Funeral Di completely filled in edical 29e. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at tha time, dete end pleca, and due to the cause(s) and manner steted. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Dey, Year) 10 85280000 June 18, 1999 Ma 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 2309 Shorefield Rd. , Wheaton, MD 20902 Daphna Henkin , MD 31. Date fited (Month, Day, Year) 32. Begistrer's Signeture State JUN 21 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Amend #19a,6/23/99, Montg. Co perF.H. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death JUNE 16, Day 1999 YEVA 7:30 PM 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death SUBURBAN HOSPITAL BETHESDA MONTGOMERY 8. Date of Birth (Month, Day, Year) 5 Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sax 7. Age (In yrs. last birthday) Days 1□M 2□F Months Hours Min Yrs. 83 RUSSTA 290-80-1638 1915 Usuel Residence of Decedent 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5901 MONTROSE ROAD #C600 20852 UNITED STATES 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Maritai Stetus Black, White, etc. 1 ☐ Yes 2 ☐ No
If Yes, Give
Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) TEACHER EDUCATION 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ALEXANDER MEREMINSKY ROSA FARBER 19a. Informant's Neme/Reletionship (Type, Print) Husband 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (SON) 5901 MONTROSE ROAD - ROCKVILLE, MARYLAND 20852 MICHAEL PINSKY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4 Donation 5 Other (Specify) 6/20/99 MENORAH GARDENS ROCKVILLE, MARYLAND 21. Signature of Funeral Ser 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS. INC. MIX 1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852 3a. Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or flean failure. List only one cause on each line. reproximate Interval Between Onset and Death Immediate Cause (Final dease or coording in death) VENTRICVUAR FIBRILLATION MINUTES DISEASE YEARS CORONARY ARTERY Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of genth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy PERIPHERAL VASCULAR DISEASE n of cause 1 Yes 20 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician/Medical

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Completed

Be

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Certification:

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Physician

/Medical

Examiner

Funeral

Director

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"natural", or

filed within 72 hours after Hygiene. ther than "natural", or he

Pages 1 and 2 should be french of Health and Mental Part II flem 27 is marked of

Department of Health a Important: If Nem 27 is any injury or other tree

Baltimore, Maryland 21215-0020

Director

Funeral

þ

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events required.)

that initiated events resulting in death) Last

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.

ISCHEMIC CARDIOMYDRATHY

END-STAGE RENAL DISEASE

25. Was case referred to medical 1 Inpatient

1 Yes 2 No 27. Manner of Death

5 Pending 2 C Accident 6 ☐ Could not be 3 Suicide

4 Homicide 29a. Certifier 🗺 Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated.

investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

2 ☐ ER/Outputient 3 ☐ DOA

28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Flural Route Number, City or Town, State)

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

(Check only one) 2 Medical Examiner: On the basis of examinetion and/or Investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number 041311

29d. Date signed (Month, Day, Year) JUNE 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

yuri U. Lleychok

6410 ROCKLEDGE DRIVE #200 - BETHESDA, MARYLAND 20817-1809 YURI A. DEYCHAK -

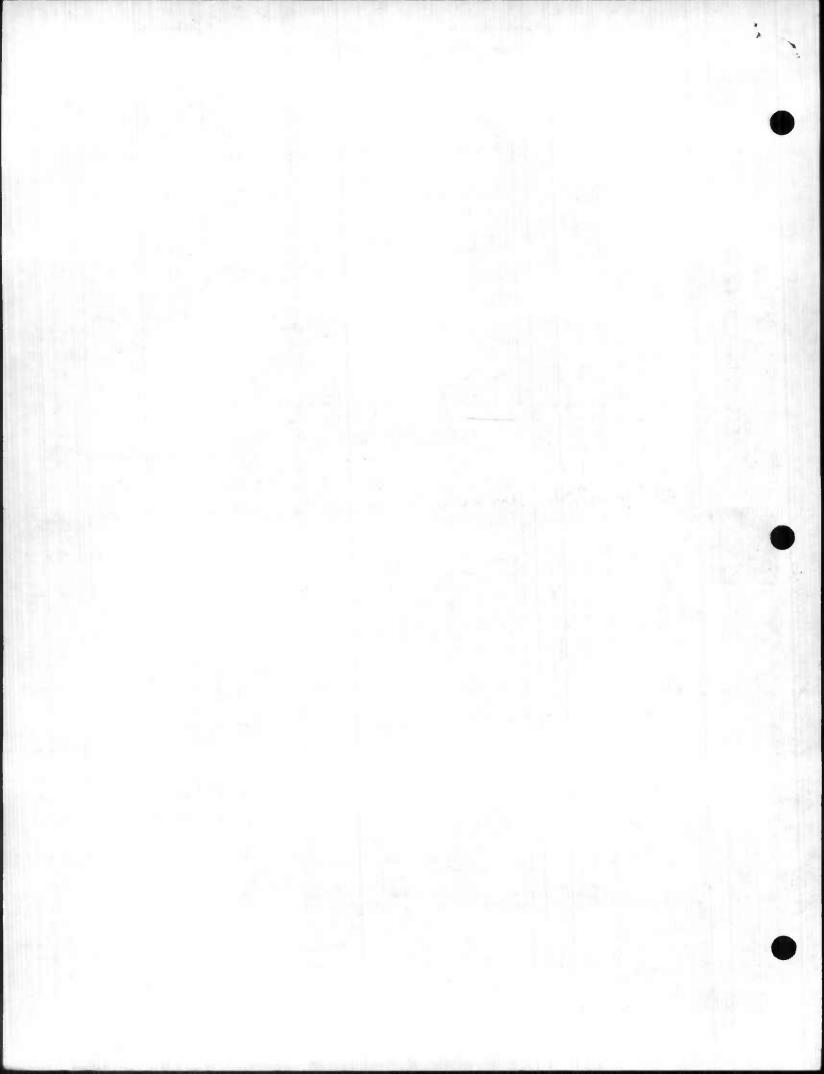
State Registrar 31. Date filed (Month, Dey, Year)
JUN 2 1 1999

32. Registrar's Signeture

6

To the House within 24 hours of To the Funeral D

3



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1 Decedant's Nama (First Middle Last) 2. Dete of Death 3. Time of Caseth Month **Physician** 16, 1999 Edward C. Pomeroy June 4:05 AM /Medical 4a Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney
If Under 24 Hrs. Montgomery 7. Aga (In yrs. last birthday) 82 Yrs. If Undar 1 Yaar 5. Social Sacurity Number Birthplece (State or Foreign Country) 8. Data of Birth **Funeral** 1⊠M 2□ F Deys Hours Min Director 012-24-6155 July 26, 1916 Massachusetts Usual Rasidanca of Decedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itsm 27 is marked other than "natural", or items 23s or 28s-f show eny injury or other treumstic event, the Medical Examinal must be notified an enge. 10a. Stata 10b. County 10c. City, Town or Location 10d. fnsida City Limits 1 ☐ Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 15519 Prince Frederick Way 20906 United States Funerai 12. Was Decedant Ever in U.S. Armed Forcas? 13. Wes Dacedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Maritei Status 1 ⊠Yas 2 □ No tt Yas, Give Yaar or Datas: WW II 1 ☐ Navar Marriad 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedant's Education (Spacify only highest grede completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16h Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Educational Administrator 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Silas C. Pomerov Minnie E. Coffin 19e. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Straat end Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) 15519 Prince Frederick Way, Silver Spring, MD 20906 Marguerite O. Pomeroy/Wife 20b. Piaca of Disposition (Nama of camatary, cramatory or other placa) June 17, 1999 20e. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☑ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Funaral Sarvica Licensea

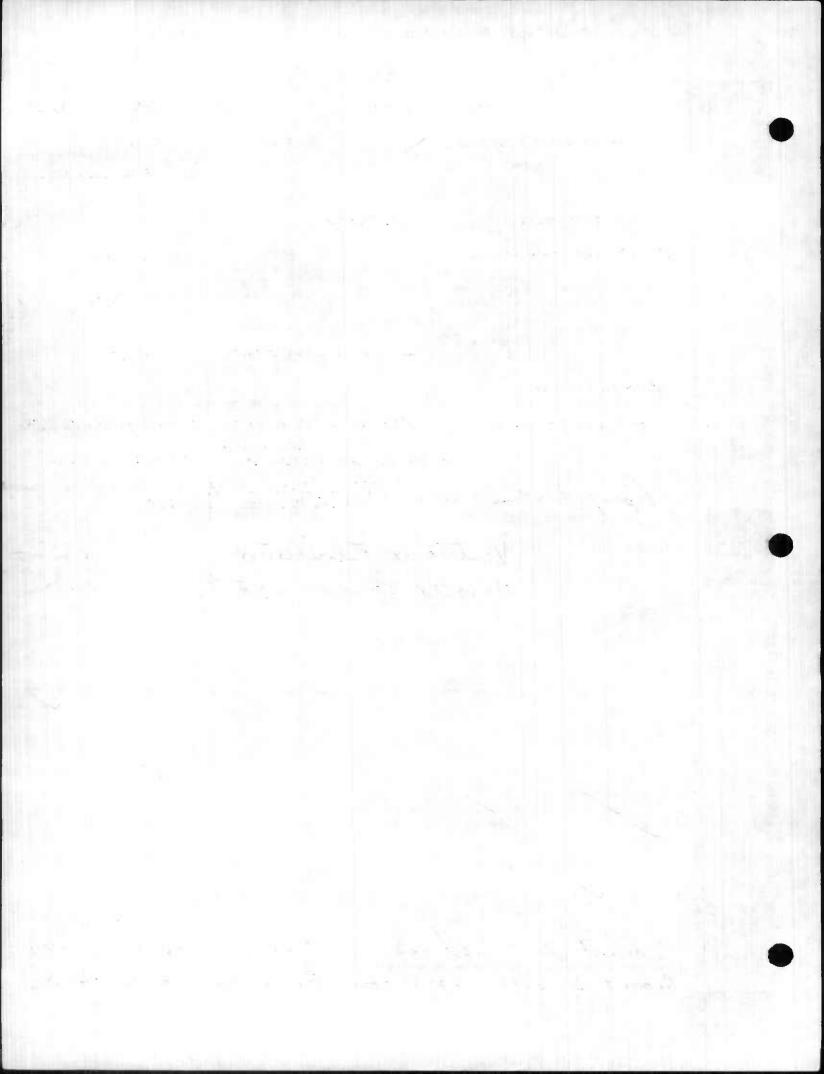
Robert A. Pumphrey Funeral Home/Rockville, Inc.

M00198

23a. Part1. Enter the disaasa, or complications that causad tha death. Do not antar the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Intarval Batween Onset end Death **Physician** /Medical Immediata Causa (Finai disaasa or condition rasulting in daath) Examiner Examiner that the death certificate be executed physician and the burial-transit Sequantially list conditions, if any, laading to immediata causa. Entar Underlying Causa (Disaasa or Injury that initiated avants rasulting In daath) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequanca of): as USB ō signed by the e Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 Donknown þ 24b. Wara autopsy findings available prior to been si 24a. Was an autopsy Completed complation of causa of death? certificate has lirector, page 2 s 1 Yas 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: director. 25. Was casa ratarrad to medical axeminar? Be 26. Placa of Daath (Chack only ona) Hospital: Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 1 Inpatiant 1 Yas 2 No Certification: To 2 ER/Outpatient 3 DOA \$ L funerai 28a. Data of Injury (Month, Day Year) 27. Mannacer Daath 28d. Dascribe how Injury occurred 28b. Time of 28c. Injury at Work? 1 ENatural 5 Panding n 24 hours after death.

The Funeral Director: After the furnitude of the 1 Yas 2 No invastigation 2 Accidant 6 Could not be datarmined 3 ☐ Suicida Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, ferm, straat, factory, offica building, atc. (Specify) 4 Homicida 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiar edicai (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. within 2 To the F 29b. Signatura and titla of certifian 29c. Licanse number 29d. Data signed (Month, Day, Year) MD JUNE 16, 1999 0 30. Nama and addrass of parson who complated causa of death (itam 23a) (Type, Print) Grove Rd. Rockville Md Shady 15225 60 31. Dete filed (Month, Day, Year)
JUN 21 1999 32. Pegistrar's Signetura State Registrar



State of Maryland / Department of Health and Mental Hygiene Q Q

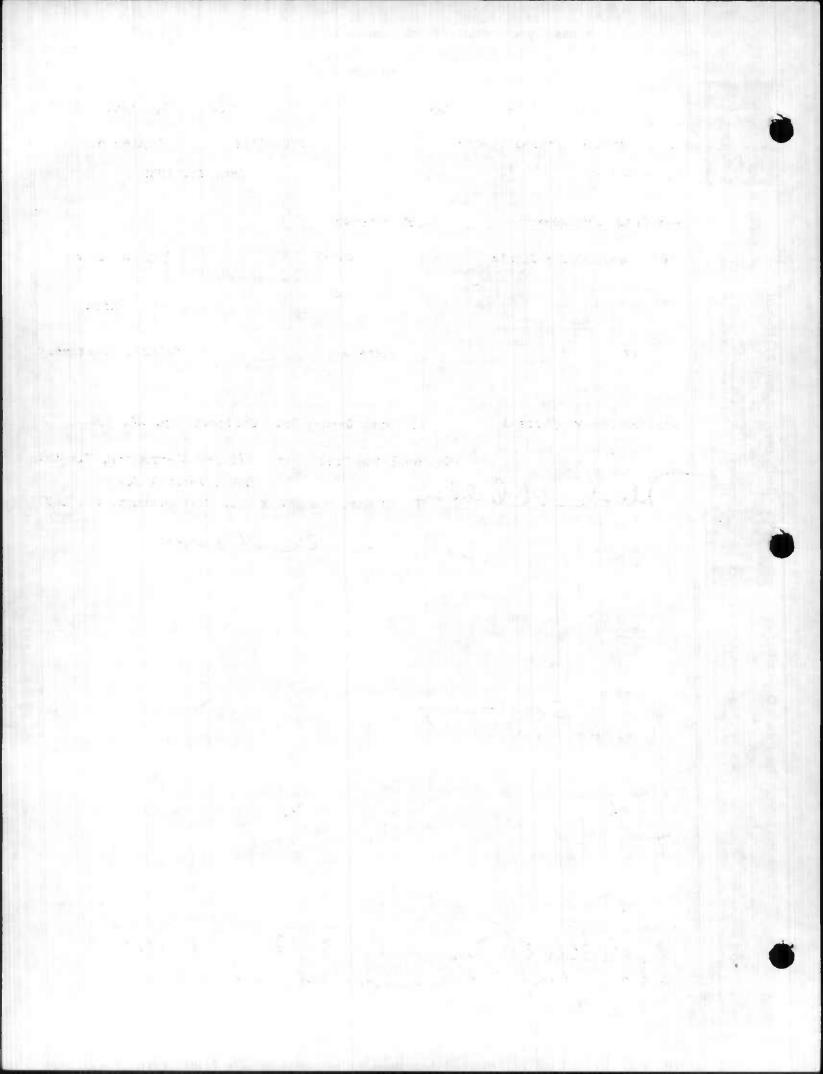
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Day Year Physician 17, 1999 Mary Ellen. Price June 8:40 PM /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Rockville
If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year) Collingswood Nursing Center Montgomery Birthplace (State or Foreign Country) If Under 1 Year 5 Sociel Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** 1□M 2⊠F Months Days Yrs. 235-56-3233 62 Dec. 26, 1936 West Virginia Director Usual Residence of Deceden with the Maryland 10a Stete 10b County 10c. City. Town or Location 10d Inside City Limits r 28a-f show 1 ☐ Yas 2 ☐ No Directo Maryland Montgomery Gaithersburg 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Modical Examiner must be a 20879 18221 Lost Knife Circle United States death Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yas ≥ 2 No
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Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. Biack, White, etc. Peges 1 and 2 should be filed within 72 hours efter inent of Health and Mental Hygiene.
Art. If New 27 Is marked other than natural; or Health yor other thaumalic event, the Modical Empires my or other thaumalic event, the Modical Empires. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 ⊠ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grada completed) Elementery/Secondary (0-12) College (1-4or 5+) Federal Government 12 Secretary 18. Mother's Neme (First, Middle, Maiden Sumama) 17. Fathar's Name (First, Middle, Last) Price Edgar Marie Gertrude Bowers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Pnnt) William Donovan/Friend 15 North Summit Dr., Gaithersburg, MD. 20877 20a. Method of Disposition 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cramation 3 ☐ Removal from State permit. Pege Department of Important: if any Injury or 6/18/99 Alexandria, Virginia 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 22. Nama and Addrass of Facility 21. Spoature of Funeral Sarvice Licansaa DeVol Funeral Home 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest,

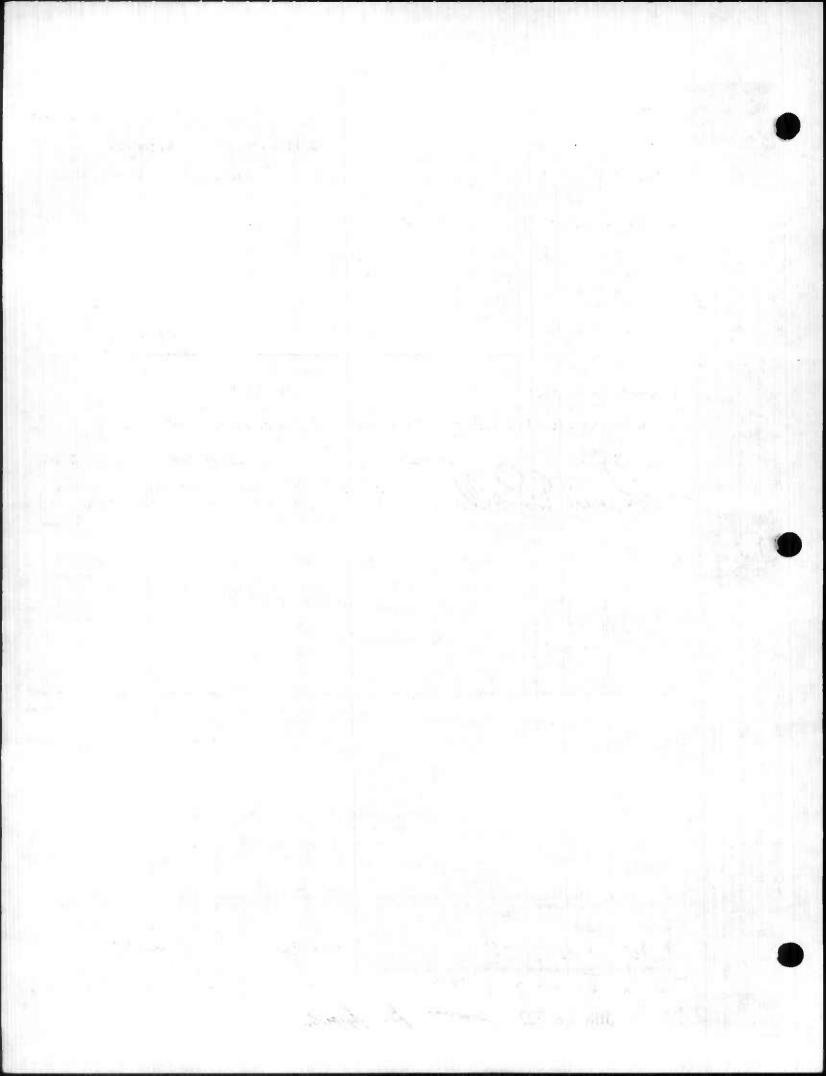
Approximate

Approximate Approximete Interval Between Onset and Deeth Physician (B) Left Lung Carcinoma /Medical Immediate Cause (Finel 6 m 05 disaase or condition resulting in death) Examiner Examiner physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thei initiated events resulting in death) Last Due to (or as e consequenca of): certificete be exec Box 68760. Physician/Medical Dua to (or as e consequanca of): 80 esn signed by the e 23b. Did tobacco use contribute to the ceuse of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. Insufficiency 15 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveileble prior to 24a. Was an autopsy performed? Completed completion of cause of death? hes 2000 1 Yes 1 ☐ Yes 2 ☐ No certificate 25. Wes case referred to medical axeminar? or Attending Physician: funeral director, Be 28. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred Naturai 5 Pending after death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, straet, factory, office building, etc. (Specify) 281. Location (Straef and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edical (Check only one) within 2 the 29d/Date signed (Month, Day, Year) 29b. Signatura end title of certifier 29c. Licansa number 18 ROBERT MILLHAN e of deeth (Item 23e) Type, Print) 30. Name and eddress of person who completed ca H Mayland Medical Conter 150 Rockville 31. Dete filed (Month, Day, Year) JUN 2 2 32. Registrar's Signeture State 1999 Registrar

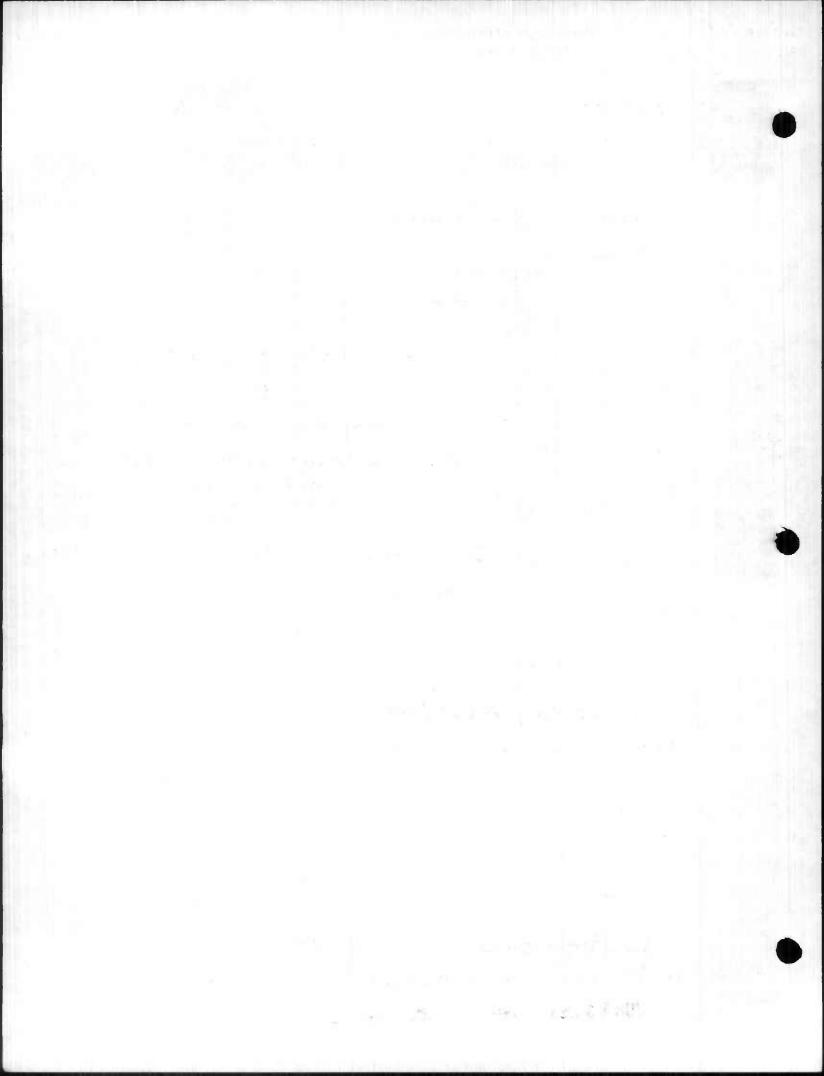


				C	ertificate of	Death		Reg. No.	9 215	196
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/Medica		Raymond T. Pa	yne				June :		12:1	5 a.
Examine	er	4a. Facility Name (If not institution, gi	ive street and number,)		4b. City, Town, or L	ocation of Deat	h 4c. County	y of Death	
	- 6	Deer's Head				Salisbur			omico	
uneral			Sex 7. As 1⊠M 2□F	ge (In yrs. last birthda	y) if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, De	rth ay, Year)	9. Birthplace (State Country)	or Fore
rector		214-16-7239	1 <u>00</u> IN 201	78 Yrs.			April	6,1921	Maryland	
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8 23	era	Deer's Head Hosp			21801			T 2	USA	
al', or items 23s or 28s-f show Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	1011	 Was Decedent of F if Yes, specify Cub 	tispanic Ongin? (Sp an, Mexicen, Puerto	Pecify Yes or No Ricen, etc.)	D- 14. Had Bia	ce - Americen indian, ck, White, etc.	
0	by F	1 Never Married 2 Merried 3 ☑ Widowed 4 Divorced	1 X Yes 2 ☐ If Yes, Give	1947	1 ☐ Yes 2 🗓 No	Specify:		Specify	y: White	
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0 A 00		21. Signature of Funeral Service Lice	my V	11	22. Name and Addre	ss of Fecility	1212	014 0000	n City Ro	o d
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		23a Fart Enter the disease, or consultations, or heart feilure. List only	nplications that cause	the death. Do not e	nter the mode of dyir	ng, such as cerdiac	or respiratory e	rrest,	Approxim	ate
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State of Maryland / Department of Health and Mental Hygiene

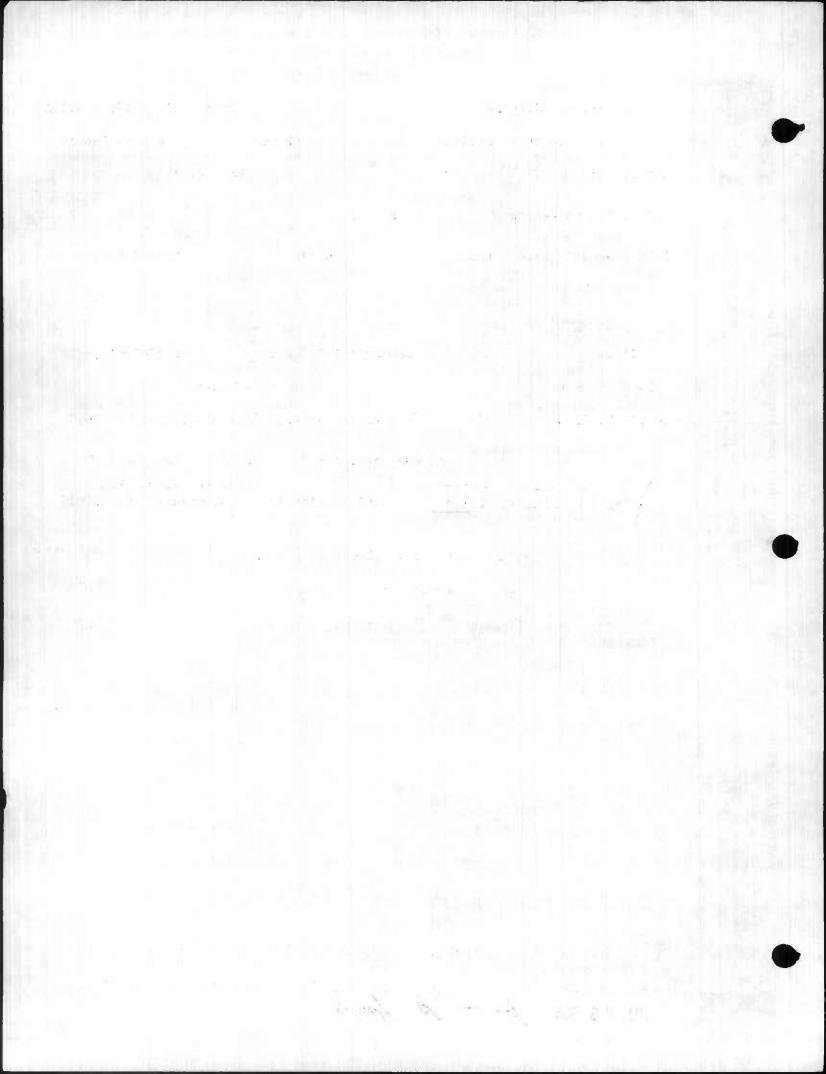
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State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First Middle | ast) 2. Date of Deeth 3. Time of Death **Physician** Robert L. Richmond June 21 1999 6:18AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 6. Sex 1 → 2 → F 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Months Yrs 246-56-4413 60 8, 1939 Director Feb. North Carolina Usual Residence of Decedent with the Marylend r 28a-f show 10e. State 10b. County 10c. City, Town or Location 10d. tnside City Limits Maryland Prince George's Riverdale 1 □ Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with and Mentle Hygiene.

mri filem 27 is marked other than "natural", or flems 23a or it yor other traumatic avent, it is was a supported or the standard or it is was a supported or it is supported to the supported to the supported or it is supported to the supported or it is supported to the supported or it is supported to the supported or it is supported to the supported or it is supported to the supported or it is supported to the supported to the supported or it is supported to the supported or it is supported to the supported or it is supported to the supported to the supported or it is supported to the supported or it is supported to the supported or it is supported to the supported or it is supported to the supported to the supported or it is supported to the supported or it is supported to the supported or it is supported to the supported or it is supported to the supporte 5409 Riverdale Road, #J5 20737 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 X Merried 1 ☐ Yes 2 ☐ No Specify: Specify: Black p 3 Widowed 4 Divorcad Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th Commercial Cleaner Self-Employed 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) John Richmond Nora Wiley 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 5409 Riverdale Rd., #J5; Riverdale, MD 20737 Dessie M. Richmond - Wife 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removel from State 6/26/99 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park Landover, MD 22. Name and Address of Facility re of funeral Service Licenses Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. ewant 20019 inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical minutes · Myocardial Insarction Examiner Examiner years Diabetes mell The law requires that the death certificate be executed attending physician end for use es the bunel-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last Due to (or as a consequenca of): 4 ears Division of Vital Records. P.O. Box 68760. Renal Failure Physician/Medical Due to (or as a consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hnknown g 24b. Were autopsy findings evallable prior to completion of cause of deeth? should I 24e. Wes en eutopsy performed? Completed s certificete hes t director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 No director. or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1☐Yes 2☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral Certification: 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of After 5 Pending 1 SNatural 1 ☐ Yes 2 ☐ No investigation after death Director: A in by the f 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide A 24 hour. Hospital 29a. Certifier 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and plece, end due to the cause(s) end manner as stated. edical To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Day, Yeer) 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 369 Hospital Dr. Choverly, md. 20785 Deburah Sherr:11 ms 3001 62. Registrar's Signature 31. Dete filed (Month, Day, Year) State JUN 2 3 1999

Registrar



State of Maryland / Department of Health and Mental Hygiene Q Q 2160

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29d. Dete signed (Month, Day, Year) 6/22 (99

30, Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

WWW AM 1304CE 16 Husp 300 Hosp 30 vive Chevry Mb 20787

31. Dete filed (Month, Day, Year)

JUN 25 1999

32. Registrer's Signeture

State Registrar

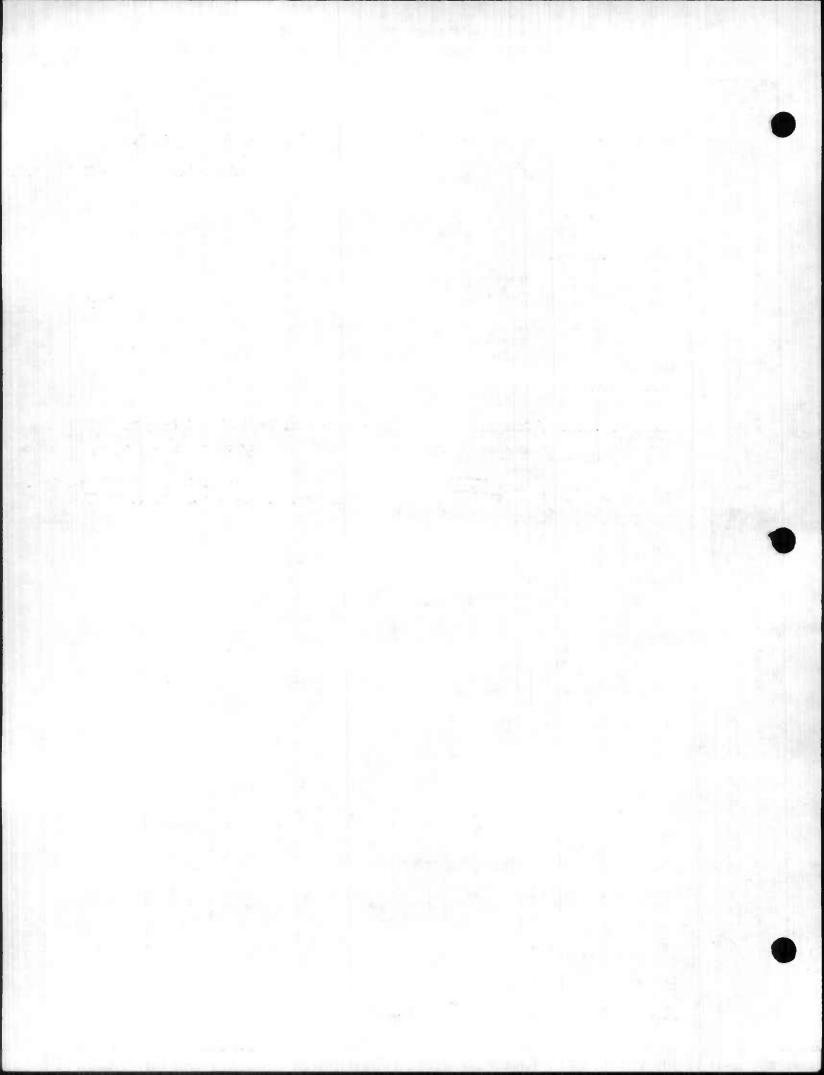


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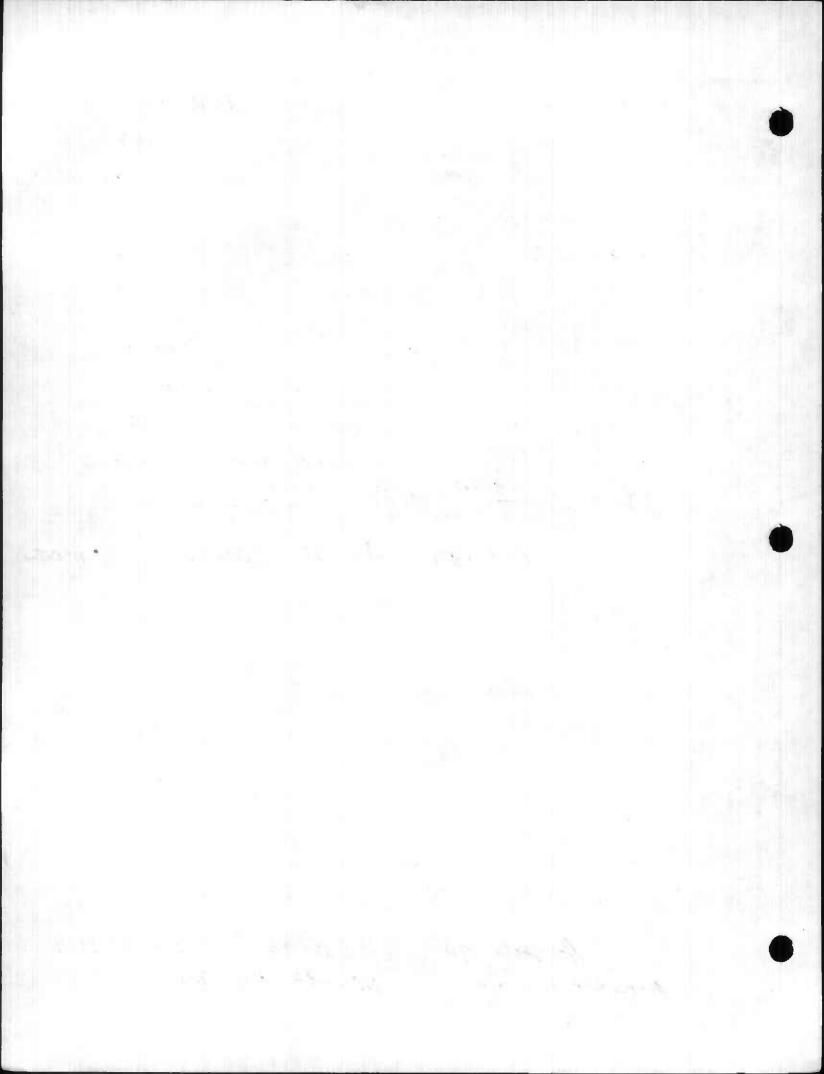
V. 2

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** Estella 215+ Robinson 1999 Sune 1:40 Am /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Nursing Home & Rehabilation Clinton, MD P. G. If Under 24 Hrs. 5. Social Security Number If Under 1 Yaar 6. Sex 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Days 10M 20F Hours Months 577-54-1411 65 Edgefield, Director July 9,1932 Usual Rasidance of Decedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD P. G. XX Yas 2 No Director Capital Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6711 Weston Ave. 20743 USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedant Evar in U.S. Armed Forcas? 14. Race - Amarican Indian, 11. Marifal Stafus Black, Whita, atc. Remit. Peges 1 and 2 should be filed within 72 hours after 19 dearment of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or the any injury or other traumatic event, the text of the page. 1 ☐ Yas 2 XNo If Yas, Giva Nevar Married 2 ☐ Married 21215-0020 1 ☐ Yas XX No Specify: by 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usuel Occupetion (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Cotlega (1-4or 5+) 2 yrs. Domestic Cleaning Baltimore, Maryland 17. Father's Nema (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Be Mary Simmons George Robinson 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19e. informent's Name/Relationship (Type, Print) 6711 Weston Ave. Capital Heights, MD 20743
Disposition (Nama of Data 20c. Location - City or Town, Stata Geneva C. Jones / Daughter 20b. Place of Disposition (Nama of comatery, crematory or other place) 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 6/29/99 Wash., D. C. 21. Signature of Funaral Sarvice Licenses 22. Nama and Addrass of Facility James E. Vann Funeral Hm. Inc. le 4804 Ga. Ave. N. W., Wash., D. C. 20011 23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not enter tha mode of dying, such as cardiac or respiratory errest, shock, or haart failura. List only ona cause on aach line. Approximate Intarval Between Onset and Death **Physician** /Medical Immediafa Causa (Finai 1ears disaasa or condition rasulting in daath) Examiner Due to (or as a consequence of) Examiner bet physician and the burial-transit that the deeth certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated avents rasulting in death) Last Due to (or as a consequenca of): Box 68760 Physician/Medical Dua fo (or es a consequance of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? P.O. 3 Probably 4 Qunknown 1 Yss 2 No signed i Records, þ The law requires 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed complation of cause of death? page 2 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital Physician: 25. Was casa rafarred to medical examinar? Be 26. Place of Death (Check only ona) To Hospital: Other: Mursing Homa 5 ☐ Residence 6 ☐ Other (Specify) 1 Yas 2 No 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28a. Data of tnjury (Month, Day Year) 27. Mennar of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred re Hospital or Attending Pl n 24 hours after death. The Funeral Director: After the pletely filled in by the funeral Certification: 1 CaNatural 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 Accidant 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be determined 3 Suicide 28a. Ptace of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicida 1 Cortifying Physician: To the best of my knowledga, daath occurred at the time, date end placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, data end place, and due to the cause(s) and manner stated. 29e. Certifier Medical pletely (Check only one) To the To the To the F 29b. Signature end titla of certifiar 29c. License number 29d. Date signed (Month, Day, Year) 046478 6.23.99 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) 7501 Surratts Rd #307- Clonton-MD20735 Suresh A. Patelm'D. 31. Dafa filed (Month, Day, Year) 32. Registrar's Signatura State JUN 2 4 1999 Registrar

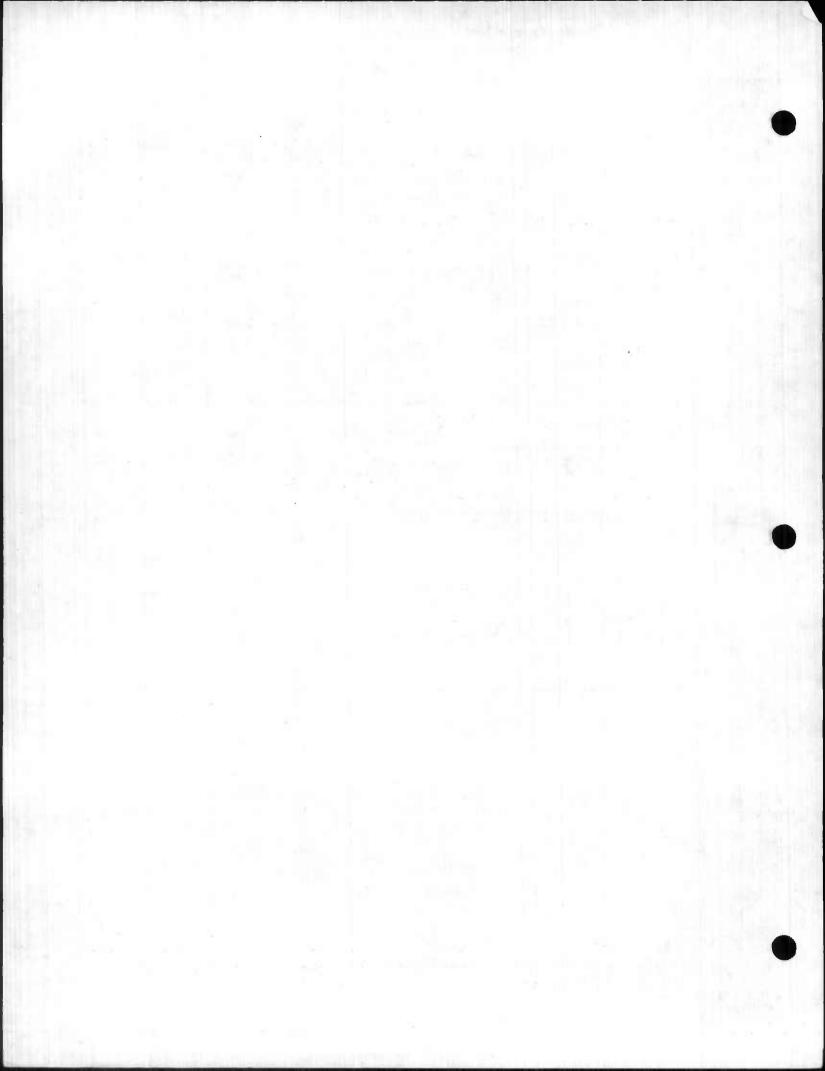


_		Decedent's Name (First, Middle, L.)	State of Maryla	Certific				Reg. No.	3. Tima of Death
	Physician						Month	Day Ye	ar
	/Medical	BERTHA LOUISE 4e Fecility Name (If not institution, go				4b. City, Town, or L	JUNE 2!		11:00 PM
	Examiner	17901 Aquasco				Brandywi			GEORGE'S
F	uneral				der 1 Year	If Under 24 Hrs.	8. Dete of Birt (Month, Da		Birthplace (State or Foreign Country)
	irector	578-56-6407	1□M XPF 56	Yrs. Mont	hs Days	Hours Min.			est Virginia
pu	100	Usual Residence of Decedent 10a. State 10b. County	100 (City, Town or Location					10d, Inside City Limits
aryle	show at								1 ☐ Yes 2 X No
the M	or 28a-f s be notified Director	Maryland Prince	George's Bra	andywine	Zip Code	-		10g. Citizen of Wha	
with	D D	17901 Aquasco	Pond		20613				SA
Seath	r items 23a pirec must Funeral	11. Merital Status	12. Wes Decedent Ever in			Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No		Americen Indian,
21215-0020 d within 72 hours effer death with the Maryland clene.	by Br.	1 ☐ Never Merried 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:		specify Cub s 🚻 No		Rican, etc.)	Specify:	White, etc. White
5-0 72 hg	"natural", adcal En	15. Decedent's E (Specify only highest p	Education	16a. Decedent's L	Jsual Occup	pation during most of work	cina	16b. Kind of Busin	ess/Industry
ithi e	nt, me Medical	Elementary/Secondary (0-12)	computer						
d 2121 filed within Hydiene.	vent, in	17. Father's Name (First, Middle, Las	a (First Middle	Maiden Sumame)					
ylane	m		.,,			Mildred			
Maryland of 2 should be file	s merked numetic e	John Bostic 19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Add	ress (Street			er, City or Town, Ste	te. Zip Code)
		Alfred H. Reed (e, MD 206						
	# K	20a. Method of Disposition	20b.	. Plece of Disposition (cemetery, cremetory	Name of	1	Dete	20c. Location - City	
Pages	世古	1 X Burial 2 ☐ Cremation 3 4 ☐ Defration 5 ☐ Other (Spec		aryland Ve			1-99	Cheltenh	am. MD
alti ourte	y injury	21. Signature of Furneral Service Lice	enaee	22. Name	and Addre	ess of Facility		OHOT OOM	um, .22
m 88	any any	1 John 14 9	M00173			wein Mort		1s., MD 2	0695
		23a. Pt. 1. Enter the disease, or cor	nplications that caused the de						Approximete the three th
/M Exa	esician ledical aminer	Immediate Cause (Final disease or condition resulting in death)	r	8 months					
58760, cate be executed	physician and stressit the bunal-transit delical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	o ⁿ ba	1					
	000	that initieted events resulting in death) Last							
BOX (death certif	atten 1 for u	Dati Ohardalita da di		h			one pid	1-h	huda da dha assas ad dassa d
P. ^{jā}	igned by the attending be detached for use e by Physician/M	Part II. Other significant conditions	contributing to death but not re	esuting in the underlyk	ng cause gr	ven in Part I.			□ Probably 45 Unknown
Records,	should should						24a. Wes perfo	an autopsy med?	4b. Were autopsy findings available prior to completion of cause of death?
	te has bage 2						10	Yes 2000	1 ☐ Yes 2 ☐ No
	s certificate had director, page	25. Was case referred to medical				26. Place of Dee	th (Check only o	one)	
of Vita Physician:		examiner? 1 ☐ Yes 2 No	Hospitel: 1 Inpatient 2	☐ ER/Outpatient 3☐	DOA OI	her: 4 Nursing H	ome 5 Resi	dence 6 Other (Specify)
	After the funeration:	27. Manner of Death 1 Natural 5 Panding 2 Accident Investigation		28b. Time of Injury	28c. Inju Wo 1	ny at ork?] Yes 2 ☐ No	28d. Describe	how injury occurred	
2 9 4	To the Funeral Director: After to completely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could not determined	28e. Placa of Injury - At building, etc. (Spec	office 28f. Location (Street and Number or Rural Ro City or Town, State)			or Rural Route Number,		
the Hospital	To the Funeral Completely filled	(Check only 2 Medical Exa	miner: On the basis of examin	I place, and due to the cause(s) and manner as stated. h occurred at the time, date and placa, and due to the cause(s)					
the thin 2	Med Med	29b. Signature and title of certifier	and menner steted.		29c. Licens	se number		29d. Date signed (A	Aonth, Day, Year)
D W	4 8	All and the or contribution	balando 1,7		Du	462 PL		June 2	
		30. Name end address of person was	or impleted cause of death (Its UELU, M)	em 23a) (Type, Print)	MID	se number +62 46 orf M	D 2	0602	
	State	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature /	1	4	_		
	Registrar	HIM 9 0 1	agg Departer	47.	A Billo A	854 /			



State of Maryland / Department of Health and Mental Hygiene

				, ,	Cer	tificat	e of	Death		Reg. N) J J	4	160	14
		1. Decedent's Nama (First, Middla, Last)						2. Date of De	ath		Year	3. Tima o	d Death
Physic /Medi			Anne	M	1.		Re	egula			1999	.,	11:15	5 AM
Exami		4a Facility Nama (If not institution, giva	street and number)					4b. City, Town, or		-	c. County of		11.10	2 44 4
		2908 Red Lion La	ne					Silver S	Spring	1	Montg	omerv	,	
Funeral		5. Social Security Number 6. Sa	x 7. Ag	ge (in yrs. last	birthday)		r 1 Year	If Under 24 Hrs	6. Date of Bir	th	1		aca (Stata o	or Foraign
Director		098-14-2171 Usual Rasidence of Decedent]м 2∏(Г	75	Yrs.	Months	Days	Hours Min	Jan. 13			New		
in g m		10s. Stata 10b. County		10c. City, T	own or Loc	cation						10	d. Inside C	City Limits
ser death with the Maryland thems 23e or 28e-f show ther must be notified at	io	Maryland Montgome	rv	Si 137	er Sp	ring							1 🗌 Yes	2 No
5 8g	Directo	10e. Sireel and Number	-17	DIIV	er bp	10f. Zig	Code			10g. C	itizen of W	hat Counti	ry?	
The or		2000 P. 1 Idaa I.a.				0.0	.001			IIm	ited :	Ctoto		
1 5 m	era	2908 Red Lion Lan	12. Was Decedenl	Ever in U.S.	13. W		904 dent of H	lispanic Origin? (: an, Mexican, Pue	Specify Yas or No			- America		
20 Paragraphics	by Funeral	1 ☐ Never Married 2 🗓 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yas 2 ☒ If Yes, Giva Year or Dates:			Yas, spe		an, Mexican, Pue	rto Rican, etc.)		Specify:	White, e		
72 hour		15. Decedeni's Edu	ASTRI ALCOHOLIS	1	6a. Deced	ent's Usu	el Occur	ation		16b.	Kind of Bus			
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Completed	(Specify only highest grad	a completed)		(Giva I	kind of wo	ork done	during most of wo	orking			,		
within with and the Man	E	Elementery/Secondary (0-12)	College (1-4or	5+)	Manac	202				R:	ank			
D PER D								18. Mother's Na	ma (First, Middle			a)		
ed be	17. Father's Nama (First, Middla, Last) Edward George Meyer Anna							Anno		D == = =				
ahoutd nd Man marks umartic	F	Ď.								Dre		State Zin I	Code)	
Ma nd 2 a 27 la u				band)		ne as		a	ar r round r round	Ji, Ony	J. Town, c	orania, ampli	, , ,	
		Stanley J. Regula 20a. Method of Disposition	(IIus		e of Dispos				Date	20c	Location - (City or Tow	un Stata	
Sattimore, Jemit. Pages 1 ar Separtment of Hear mportant: If New 3 my injury or other Mice.		1 ☐ Burial 2 ☐ Cremation 3 ☐ F	lemoval from Stata	com	etary, crem	atory or o	othar plac	ce)	Date	EUU.	LUCATION - C	ony or row	m, Statu	
nit. Pa antmer potanti injury		4 ☐ Donation 5 ☐ Othar (Specify)		Che	sapea				6-25-99		tsvil	le, 1	Mary1	and
Sail Spanis		21. Signalure of Funaral Sarvice Licens	99		Ra	Nama er	d Addre	ss of Facility al Servi	CAS. P	Δ				
M 202 8 8		Ollen D	Kay	90				venue, S			o MI	209	10	
-		23a. Part1. Entar the disease, or compl shock, or heart failura. List only or	ications that cause	d tha death. I							153 111		Approximatintarval Bel	ite
Physician		SHOCK, OF Heart landra. List Only O	ie cause on aach ii	iiie.									Onset and	
/Medical		Immediata Ceusa (Final	Contra	l Nerv	70116 9	Sycto	m Fo	iluro				1	week	,
Examiner		diseasa or condition rasulting in death)	. Centra	Due to (or as				illule		-		1	week	
	ě		Motost	atic C			•					1	0	- 4° h -
beth b	Examiner	Securetially list and disease	recast	Due to (or as						-		1	8 mor	itns
in and in a	EX	if any, leeding to immediata												
DS/DU, tificate be executed to physician and es the burial-transit	edicai	Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events	Breast	Cance Dua to (or as		ience of).						-		
d g d	8	rasulting in death) Last		Dua to (or as	a consequ	rence ory.								
Centi	3		1											
death cert death cert e attendin ed for use	Cia								1 001 011				25	-4-4
es that the death certigned by the attendin	Physician/M	Part II. Other significant conditions cor	tributing to death b	out not rasultin	ng in tha un	idarlying o	ausa giv	en in Pert I.					the cause	*********
T tage									1	Yes	2 No	3 Prob	ably 4	Unknow
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v require been si	Completed									omed?		con	ilable prior	to
The law are has bege 2 s	du											of d	leath?	
= F # A	ပိ								10	Yes	2 X No	1 🗆	Yas 2X	No
Of Vital I Physician: The this certificate ral director, peg	Be	25. Wes case refarred to medical axaminar?							eth (Check only	one)				
- 5 00	2	1 ☐ Yas 2 ☐ No	lospitat:	ent 2 ER	/Outpatient	3 D		4 LI NUISHIY	Homa 5 ☑ Ras	idence	6 □Othe	r (Specify,)	
ding Pi After ti funera		27. Manner of Death 1 🖾 Natural 5 🗌 Pending	28a. Date of Inju (Month, Da	ly Year) 28	b. Time of Injury	1	28c. Injur Wor	y at rk?	28d. Describe	how in	ury occurre	ed		
Attending or deeth.	at	2 Accident invastigation				М	10	Yes 2 □ No						
or Attending after deeth. Director: After din by the fune	₩.	27. Manner of Death 1 All Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28b. Time of Injury M 1 Yes 2 No 28d. Describe how injury of 1 Yes 2 No 28d. Describe h									umber or Rural Routa Number,			
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To the Hospital or Attending Phy within 24 hours after deeth. To the Funeral Director: After this completely filled in by the funeral	edicai		best of my knowledge, deeth occurred at the time, date and plat asis of axamination and/or invastigation, in my opinion, death occurrent steled.									(s)		
thin o the	M	29b. Signature and little of certifier	A /			29	c. Licens	e number		29d. D	ala signed	(Month, D	Day, Year)	
		1) Emg a	Doben	D	1									
5		.57.7		U			D 17				ine 24		99	
		30. Nama and addrass of person who co			Ba) (Type, F			Medical			#210)		
		Stanley A. Schwa				S	ilve	r Spring	g, MD 209	902				
Sta	ate rar	31. Data tiled (Month, Day, Year)		rer's Signatura	4	1	a N.	,						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middla, Last) 2. Date of Death 3. Time of Death Day 99 **Physician** James Stuart Rich Sr. June 23, 4:20pm /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Undar 1 Yaar | If Undar 24 Hrs. 8. Deta of Birth (Month, Day, Year) Dec. 26,1912 9. Birthplace (Stata or Foreign Country) New York 7. Aga (In vrs. last birthday) **Funeral** Months Deys Hours 1 € M 2 □ F 076-09-2864 Yrs. Director Usual Rasidance of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Nem 27 is marked other than "naturel", or Nama 23a or 28a-f show other traumatic avent, the Medical Examinar must be notified at 1 ☐ Yas 2 ☑ No Silver Spring Director Maryland Montgomery 10a, Street and Number 10g. Citizen of What Country? 3701 International Drive #732 20906 Funeral USA 12. Was Decedant Evar in U,S Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - American Indian, Black, Whita, atc. pernit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if fem 27 is marked other than "naturel", or fles eny injury or other traumeds avent, the Medical Examinat pages. 1 Nevar Married 2 Merried 1 Yes 2 No Baltimore, Maryland 21215-0020 If Yas, Giva Yaar or Datas: 1942-45 Specify: White 1 Yas 28 No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+Manager Federal Government 18. Mother's Nema (First, Middle, Maiden Sumema) 17. Father's Nema (First, Middla, Last) Be James Henry Rich 10 Estella Chaffee 19e. tnforment's Name/Ratationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) James Stuart Rich, Jr. /Son 4601 North Park Ave. #301 Chevy Chase, MD 20815 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition July7 20c. Location - City or Town, State 1 Burial 2 Crametion 3 Ramoval from State 4 Donation 5 Othar (Specify) 1999 Arlington N.C.Columbarium Arlington, VA 21. Signature of Fuperal Se 22. Nama and Addrass of Facility
Francis. J. Collins Funeral Home, Inc. 500 University Blvd. W, Silver Spring, MD 20901 amsel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Pneumonia Examiner Dua to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, it any, leeding to immadiata cause. Entar Undarlying Cause (Disease or injury thet initiated evants rasulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Dua to (or es a consequence of) P.O. Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yaa 2 No 3 Probably 4 Unknown Arteriosclerotic heart disease Records, þ Completed 24b. Wara autopsy findings available prior to 24a. Was an autopsy Arteriosclerotic cerebrovascular disease completion of cause of death? page 2 1 ☐ Yas 2 No 1 Yam 2 No certificate Division of Vital or Attending Physicien: 8 25. Was casa refarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mennar of Death 28b. Time of 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 1 StNaturet 5 Panding 1 Yas 2 No death. 2 Accidant Invastigation hours after death 6 Could not be datarmined To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completely filled in by the 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 4 Homicida Medical 29e. Certitier 🔁 Certifying Physician: To the best of my knowladga, daath occurred at tha time, date end place, end due to the cause(s) and menner as stated. 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner stated. 290. Signature and title of certifier 29c. Licanse number 29d. Data signed (Month, Day, Year) D12121 10 June 23,1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George Sengstack 3929 Ferrara Drive, Wheaton, MD 20906

DHMH 16 Rav 6/95

State

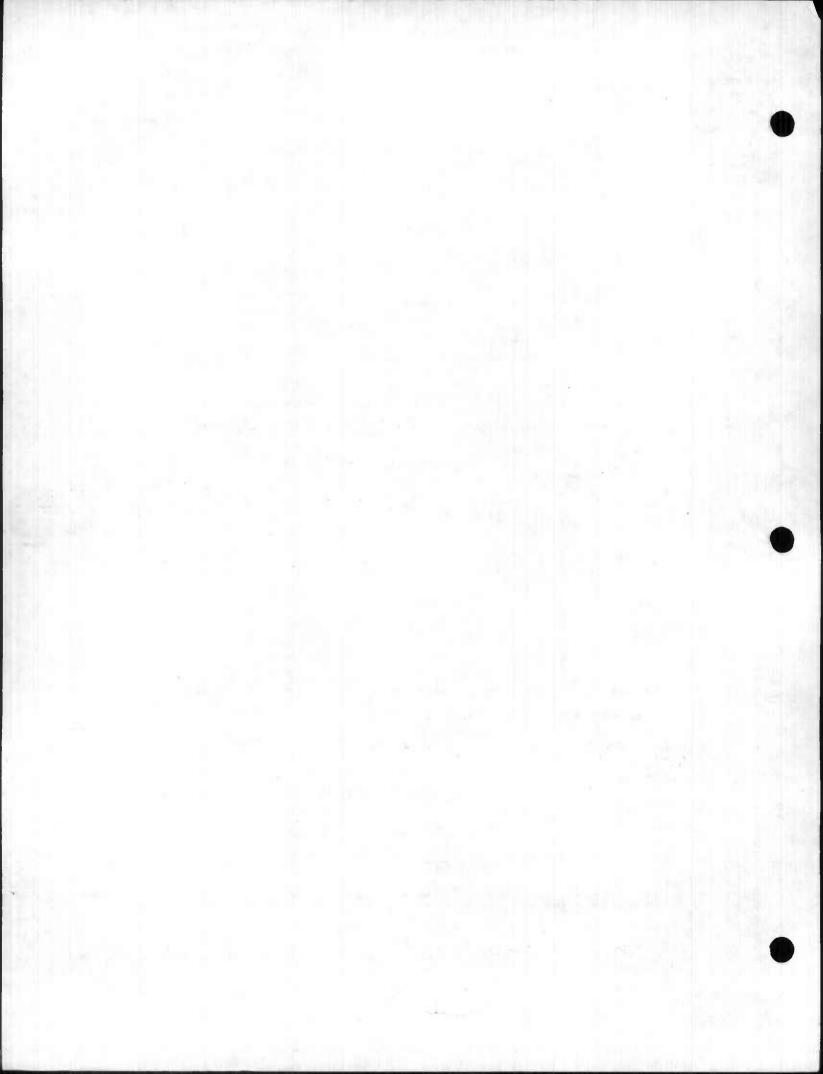
Registrar

31. Data fited (Month, Day, Year)

JUN 25

32. Registrar's Signetura

301 -942-3100



	State	of Maryla	nd / Dep	artment	of H	lealth a	and M	lental Hy	ygie	eneg g	- 2	1606
				rtificate						. No.		
1. Decedent's Name (First, Middle	e, Last)							2. Date of D Month	eath	Dey	Year	3. Time of Deeth
MARY OLI	VIA	ROBER	TS						18,	1000		7:23 AM
4a Facility Name (If not Institution	n, give street and nu	um <i>ber)</i>				4b. City, To	wn, or Lo	ocation of Dea	ith	4c. County	of Death	
WASHINGTON ADVE	NTIST HOS	SPITAL				TAKO		ARK		MONT	GOME	RY
5. Social Security Number 066-36-5100	6. Sex 1 □ M 2 □ F	7. Age (In yr	s. last birthdey Yrs.	Months I	Year Days	If Under Hours	Min.	8. Date of B (Month, D June	irth lay, Y	1920	Cou	nplace (State or Foreign untry) St. Kitt t Indies
Usual Residence of Decedent		100	Ditt. Town on I	ti							— т	40d Analda Ciby Limita
10a. State 10b. County		100. (City, Town or L	ocation								10d. Inside City Limits 1 Yes 2 No
Maryland Montg	omery	No	rth Po									X
10e. Street and Number				10f, Zip C	ode				10g	. Citizan of V	What Cou	untry?
14905 Damson Te					208					nited		
11. Marital Status	Armed F		U,S. 13.	Was Deceder	nt of h	lispenic Or an, Mexica	igin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	10-		e - Amer ck, White	rican Indian, o, etc.
1 Never Merried 2 Marr 3 Widowed 4 Divorced	ied 1 Tes If Yes, G Yeer or [2 X No ive Detes:		1 ☐ Yes 2]	No.	Specify:				Specify	<i>/</i> :	Black
15. Deceden (Specify only higher)	16a. Dece	edent's Usual a kind of work DO NOT use	Occup done	ation during mos	t of work	ing	16	b. Kind of Bu	usiness/i	ndustry
Elamantary/Secondary (0-12)	1	(1-4or 5+)		<i>DO NOT</i> use Nurse <i>A</i>						Heal:	th C	are
17. Father's Name (First, Middle,	Last)					18. Moth	er's Nam	e (First, Middl	e, Ma	iden Surnam	10)	
Unknown	1							Unk	not	770		
19e, Informant's Name/Relations			19b. Mai	ing Addrass (Street	and Numb	er or Rur				State, Z	ip Code)
Glenda Brookes,		c_in_I o	1/10	05 Dame	on	Torr	200	N Po	tom	nac MI	2	0878
20a. Method of A sposition	Daugneel		. Placa of Disp	osition (Name	of		ace,	Dete Dete	-	c. Location -		
44	3 □Removal from pecify)		ate of	Heaven				une 22 1999		ilver	Spri	ing, MD
21. Signature of Funtiral Service	Licensee		2	22. Name and	Addre	ess of Fecili	ty	DeVo1	F	uneral	Ноп	ne
Humi	n 11.		10	0 East	De	er Pa	rk D					
23a. Party. Enter the disease, or shock, or heart fallule. List	complications that	caused tha de						-			-6,	Approximate Interval Between
shock, or heart fallule. List	only one cause on	aach lina.										Intarval Between Onset and Death
Immediate Cause (Final	5	120	24								1	1814te.
diseasa or condition rasulting in death)	a	1/00	7/12	1119		1					1	10 mts.
	2	Due to	or as a conse	equence of):	10	200					1	5-1-81
	. b. 101	lat	ex 0		11	reu	m	onic	4		1	Jacy
Sequentielly list conditions, if any, leading to immediate	01	Due to	(or as a conse	equanca of):		1		1		1.	1	U
cause. Entar Underlying Cause (Disease or Injury	o. Cl	ron	ic C	3681	8	uch	ne	14n	9	dise	ask	years
that initiated events rasulting in daath) Last		Due to	(or es a conse	quenca of):				/	1		1	/
											i	
Pert II. Other significant condition	ne contributing to	death but not r	esulting in the	underlying cau	ise gi	van In Part	1.	23b. DI	d tob	acco use co	ntribute	to the cause of death?
Mening	im.		KXX	nein				10	Yes	2□ No	3) Pr	obably 4 Unknown
i crury	VIILU	8	100	401							T	
0		0						24a. Wa	as an dome		8	Were autopsy findings avellable prior to completion of cause of death?
								1 [] Yas	200 No		Yes 25 No
25. Was casa rafarrad to medical						ge pia-	o of Deci			940140		2,00
examiner?	Hospital:		☐ ER/Outpatio		Ot	her:		h (Check only		ce 6 □Oth	or /Con	

Physician /Medical Examiner

Examiner ate has been signed by the attanding physician and page 2 should be detached for use as the burial-transit Physician/Medicai by Completed To the Hospital or Attending Physician: The law within 24 hours after death.

within 24 hours after death.

completely filled in by the 'uneral director, page 2: Be Certification: To

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

27. Manner of Death

1 Natural 2 Accident

3 Sulcide

29a. Cartifier

4 Homicide

Director

Funeral

À

Completed

Physician

'- /Medical

Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-4 show any Injury or other traumatic event, the Medical Examiner must be notified at 2006.

Baltimore, Maryland 21215-0020

28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 2 No 1 Yes 6 Could not be detarmined

28e. Place of Injury - At home, farm, sfreet, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and placa, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) end manner stated.

(Check only one) 29b. Signature and IIII of certifier

29c. License number D 19 609

29d. Date signed (Month, Day, Year)
06.19.99

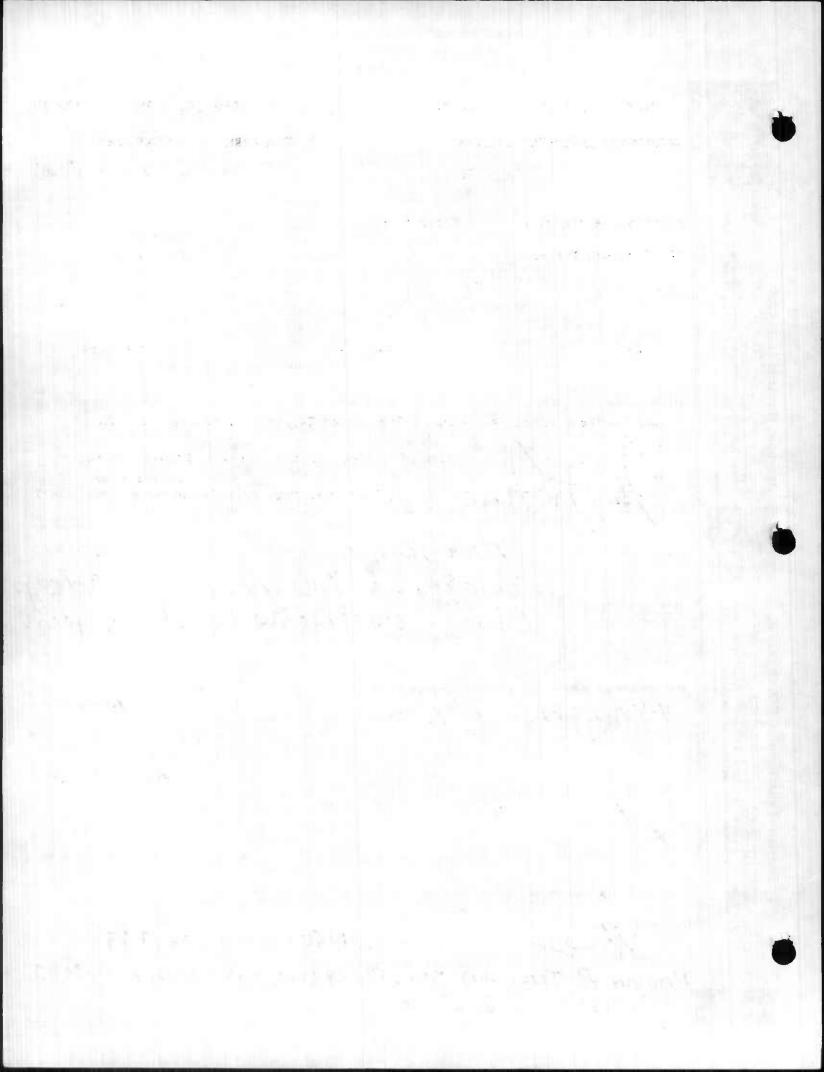
30. Name and address of person who completed cause of death (Ham 23a) (Type, Print)

RAMAN R. TULLI MD 3503 PERRY STREET MT. Rainier MD 20712 31. Date filed (Month, Day, Year)
JUN 2 2 1999

State Registrar

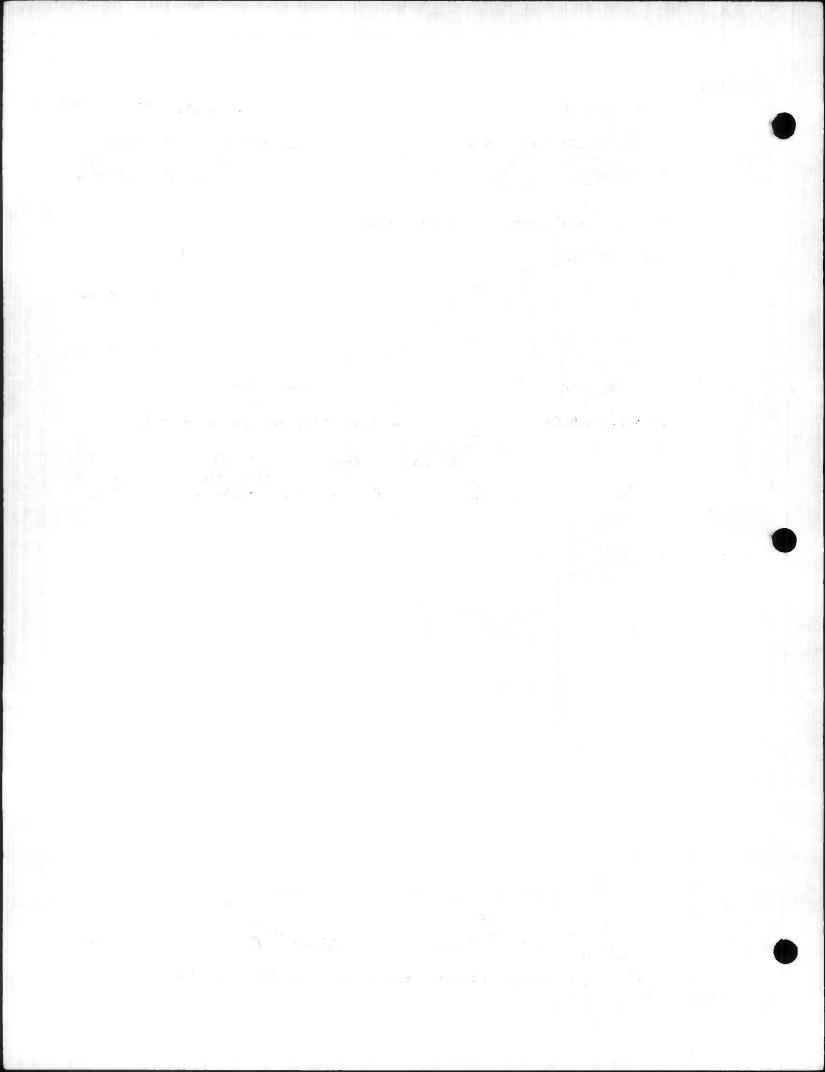
edical

32. Degistrar's Signature



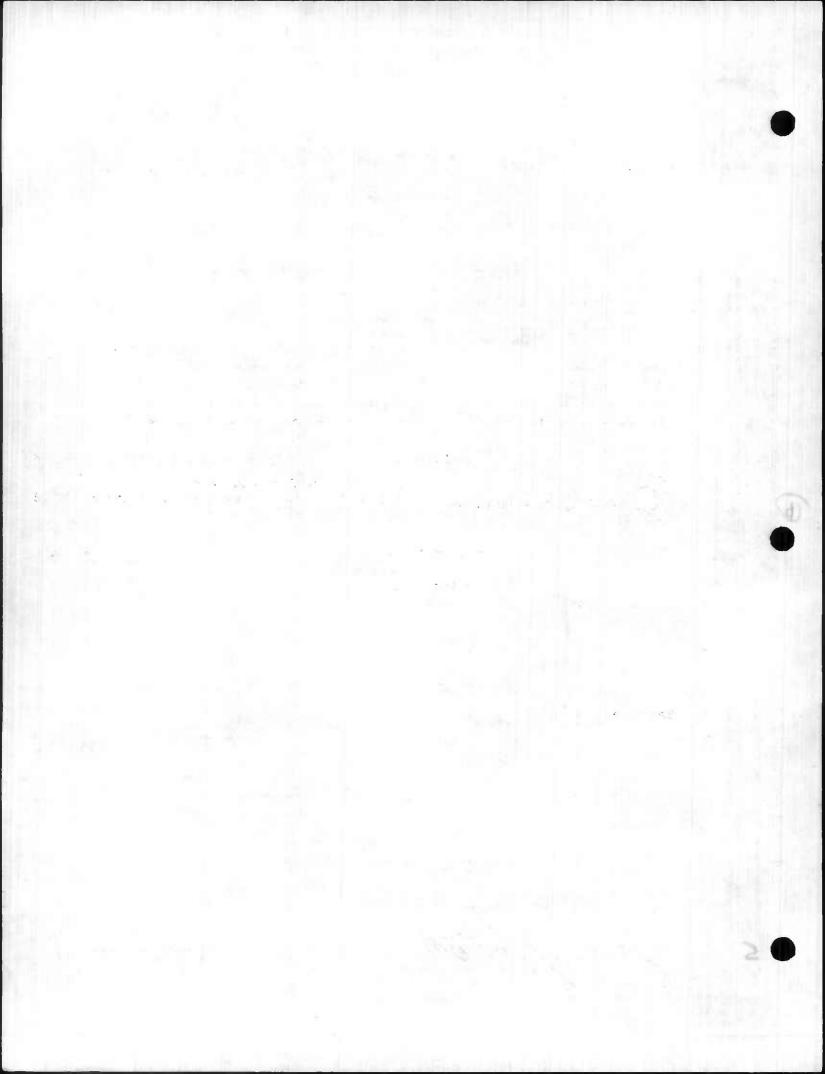
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene 2 2 6 0 7

				State of IVI	ai yiariu /		tificate of	Death	wentar my	Reg. No.	ion I	007
	·		1. Decedent's Neme (First, Middle, L.	ast)					2. Dete of D	eeth	V	3. Tims of Death
	Physici /Medio		Mayme M. Roth						June :	21, ^{Dey} 1999	Year	6:00 AM
	Examir		4a. Facility Name (If not institution, gi	ve street and number)				4b. City, Town, or	Location of Dea	th 4c. County	of Death	
			Wilson Health (Care Cente:	r			Gaithers	burg	Monte	omer	У
	Funeral				e (In yrs. lest l	birthdey)	If Under 1 Yeer	If Under 24 Hrs	s. 8. Dete of Bi		/	ace (Stete or Foreign
	Director		578-40-7833 Usuel Residence of Decedent	1□ M 20XF	92	Yrs.	Months Deys	Hours Min	Nov 1	5, 1906	Geor	
	th with the Maryland 23s or 28s-f show		10a. Stete 10b. County		10c. City, To	wn or Loc	cation				10	Od. Inside City Limits
	No M	Funeral Director		gomery	Gaith	ersb	urg					1 Yes 2 No
	ith th	Dire	10e. Street and Number				10f. Zlp Code			10g. Citizen of W	het Count	ry?
	23a	<u>a</u>	301 Russell Ave	2			20877			USA		
	ter dea	ine	11. Meritel Stetus	12. Wes Decedent Armed Forces?	Ever in U,S.	13. V	Ves Decedent of H	Hispanic Origin? (: en, Mexicen, Pue	Specify Yes or N	o- 14. Reca	- America	
Maryland 21215-0020	E 9 E	by	1 ☐ Never Merried 2 ☐ Merried 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 X If Yes, Give Yeer or Detes:			☐ Yes 2∏ No	Specify:	, 10 1 11021, 0101,		Whi	
9	72 hours "netural",	ted	15. Decedent's E	ducation	16	a. Deced	ent's Usuel Occup	pation		16b. Kind of Bu	siness/ind	ustry
21	hin 7	Be Completed	(Specify only highest gr Elementery/Secondery (0-12)	College (1-4or	5+)	life. D	kind of work done OO NOT use retire	oation during most of wo d)	orking			
2	d withir giene. rr than	ПО	Elementary Coolings (C 12)	1	y+1	Cle	rk			Federa	1 Go	vernment
Pu	off Hy	3e C	17. Fether's Neme (First, Middle, Las	t)				18. Mother's Ne	eme (First, Middle	e, Meiden Sumame)	
<u>a</u>		To	Otto Schellin					Nancy	Huggins			
ar ₂	d 2 should th and Men 7 is marks traumatic		19e. Informent's Neme/Reletionship	(Type, Print)	15	9b. Mailin	g Address (Street	end Number or F	Rural Route Numb	ber, City or Town,	Stete, Zip (Code)
	alth a		John T. Roth/So	on		4125	Queen M	lary Dr,	Olney, 1	MD 20832		
altimore,	permit. Peges 1 and 2 Department of Health a important: If item 27 is any injury or other tra once.		20e. Method of Disposition		20b. Plece	of Dispos	sition (Neme of netory or other ple		Dete	20c. Location - 0	City or Tov	wn, State
E	Peges nent of int: If its iry or o		1 Buriel 2 ☐ Cremetion 3 [4 ☐ Donetion 5 ☐ Other (Speci				Nationa		Jun 30	Arlingt	01) -	VΔ
alt:	nlt. ortai	ŀ	21. Signeture of Funerei Service Lice		ALLIN					aldi Fune		
)m	Depar impor any ir		1 along 7	Somela)							, MD 20904
	Physician		23a. Pert1. Enter the discount of conshock, or heart fellure.	nplicetions thet caused one cause on eech li	d the deeth. De	o not ente	or the mode of dyle	ng, such es cerdie	ec or respiretory a	arrest,	i	Approximete intervel Between Onset and Death
	/Medicai		Immediate Ceuse (Finel									1 Day
	Examiner		disease or condition resulting in deeth)	θ		neum						1 рау
		ē			Due to (or es	e consequ	uence or):				1	
	eath certificate be executed ettending physician and for use as the bunal-transit	edical Examiner	Sequentially list conditions	b. ————	Due to (or es	e consedi	ience of).				1	
o,	requires that the death certificate be executed een signed by the ettending physician and hould be detached for use as the burial-transit	EX	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying		200 10 (0. 00							
68760,	ysick ne bu	Cal	thet initiated events	C	Due to (or es	consequ	ience of):					
	ig ph as th	mer.	resulting in deeth) Last								1	
Box	ndin use	3		d								
8	d for	등	Part II. Other eignificant conditions	contributing to death b	ut not socition	in the con-	dashilan asusa ah	rea in Dead I	nah nid	I tabasas usa san	andburke de	the cause of death?
0	thet the de ed by the e detached	Physician/N			at not resulting	in aleun	denying cause giv	ven in Perci.				
0.	w requires that been signed b should be deta	y P	Parkinso	ns Disease						TSU ZUNO	3 P100	ebly 4 ☐ Unknown
Records,	uires sign	Completed by							24e. Wes	s an autopsy	24b. We	re autopsy findings
8	- D 00	ete							perf	ormed?	com	ilable prior to appletion of cause
Be	hes hes	Ę.								V		leath?
<u>a</u>									10	Yes 2 No	1 🗆	Yes 2 No
Vital	ysiclan: s certific director,	Be	25. Wes cese referred to medical examiner?	Hospitel:			all post Oth	ACC:	eth (Check only			
to	E -	P.	1 Yes 2 No	1 LI Inpatie		-	3LI DUA	4X Nursing		idence 6 Othe)
5	ling I	0	1 ☑Neturel 5 ☐ Pending	28a. Dete of Inju (Month, Da	y Year)	Time of Injury	28c. Injur Wor		280. Describe	how injury occurre	Ю	
2	Attending r deeth. sctor: After by the fune	Cal	2 Accident investigation 3 Suicide 6 Could not t	NA -				Yes 2 □ No	004 1	(C)	0	0-1-11-11-1
Division of	or All	Certification:	4 ☐ Homicide determined	building, et	ury - At home, c. <i>(Specify)</i>	term, stre	et, fectory, office		City or To	(Street end Numbe own, State)	r or Hurai	Houle Number,
	urs urs lifed	ပိ	X .									
	To the Hospital or Attending Pt within 24 hours eiter deelh. To The Funeral Director: After the completely filled in by the funeral	edical	29e. Certifier (Check only one) 1 ☐ CertifyIng Pl	hysician: To the best of miner: On the bests of end menner sto	examinetion e	ge, death and/or inv	occurred et the tir estigetion, In my o	me, dete and piec opinion, deeth occ	e, and due to the curred et the time	cause(s) and mer , dete and piece, a	nner es ste nd due to	ated. the cause(s)
	To the	ž	29b. Signature and yill of certifier		1		29c. Licens	se number	1	29d. Dete signed	(Month, D	Jay, Year)
	10) /h./	AWI	_		1	2051	1	June 2	2, 19	199
	•	1	30. Name and address of person who	completed cause of d	eeth (Item 23a) (Type F	Print)					
			Joel Sch					d, Bethe	sda, MD	20814		
	Sta	te	31. Dete flort (Month, Day, Year)	32. Registr	er's Signeture		0				_	
	Registr	_	JUN 2 4	- 2	enterna	36	lace	KI				



State of Maryland / Department of Health and Mental Hygiene 99 2 6 0 8

			Ce	ertificate o	f Death		R	eg. No.		
	1. Decedent's Neme (First, Middle, L	ast)		11111111			Dete of Deat	th		3. Time of Death
Physician	neren baer ca	monston Rowe					Month une 2	1, Day 1999	Year	10:02 AM
/Medica Examine	do Facility Stome Mant institution of	ive street and number)			4b. City, To	wn, or Location	on of Death	4c. County	of Death	
Examine.	Suburban Hospit	al al			Bethe	sda		Montg	omer	У
Funeral	-		yrs. last birthday	ff Under 1 Ye		24 Hrs. 8. (Date of Birth Month, Day,			placa (State or Foreign
Director	219-34-8209 Usuel Residence of Decedent	1□M 2\ F 8	9 Yrs.	Months Day	s Hours	Min. Ja	Month, Day, in. 21	, 1910	Coui I1	linois
Pu B	10a. Stete 10b. County	10c	City, Town or I	ocation					1	10d. Inside City Limits
with the Meryl or 28a-f ahd be notified	Maryland Montgom	ery Ta	ikoma Pa	rk						1 No Yes 2 No
4 4 4 4	10e. Street and Number			10f. Zip Code	•		1	Og. Citizen of V	What Cour	ntry?
£ 23 a	7101 Poplar Ave	nue		20912	2		1	United	State	es
eep L	11. Meritel Status	12. Wes Decedent Ever Armed Forces?	in U,S. 13	. Wes Decedent of If Yes, specify Co	f Hispanic Ori	gin? (Specify n. Puerto Rica	Yes or No-		e - Americk, White,	can Indian, etc.
72 hours after death with the Menyland natural, or Nerns 23a or 28a-f show acel Examiner must be notified at the families of Directors	1 ☐ Never Merried 2 ☐ Merried 3 ☐ Widowed 4 🖾 Divorced	1 ☐ Yes 2 🖔 No If Yes, Give Yeer or Detes:		1□ Yes 2) N				Specify	White	
	15. Decedent's E (Specify only highest go	Education rade completed)	16a. Dec	edent's Usual Occ e kind of work dor DO NOT use ret	cupation ne during mos	t of working		16b. Kind of Bu	usiness/In	dustry
be filed within vial Hygiene. d other than event, tre He	Elementery/Secondery (0-12)	College (1-4or 5+)		h/Englis				Educat	ion	
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Sab o									10)	
d 2 should be filed within th end Mental Hygiene. 7 Is marked other than traumetic event, the Hygienel To Be Commi		<u> </u>				Angel				
2 sh end la m raur	19e. Informent's Neme/Reletionship			ling Address (Stre						
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of Health	20e. Method of Disposition 1 ☐ Buriel 2 🖾 Cremetion 3		 b. Plece of Disp cemetery, cri 	position (Name of emetory or other p	olace)	D	ate	20c. Location -	City or To	own, Steta
Pages mart of mrt. If he ary or o	4 Donetion 5 Other (Spec		Chesapea	ke Crema	tory	6-2	2-99	Beltsvi	11e,	Maryland
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	23a. Part1. Enter the disease, or cor	nolicetions that caused the							aryı	Approximete
	shock, or heert feilure. List only	y one cause on each line.					opo			Intervel Between Onset and Death
Physician /Medical	Immediate Cause (Finel	4 . 36		T C						-
Examiner	diseese or condition resulting in death)	Acute Myo	ardial	Infarct						Immediate
			o (or es e conse							
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eeth certificate be executed attending physician end for use as the burial-transit clan Medical Examines	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due	o (or as a conse	equence of):						
flicate be physicia as the bur	Cause (Diseese or Injury thet initiated events resulting in death) Last	C. Due t	o (or es a conse	equence of):						1 1 -01
deeth certificate be executed e attending physician and of for use as the bunal-transit atclan/Medical Examir		d								
at the deeth ce d by the attend etached for us	Pert II. Other algnificant conditions	contributing to death but not	resulting in the	underlying cause	given in Pert I		23h. Did to	obacco use co	ntribute t	o the cause of death?
the the				and onlying decide			1 🗆 Y		3 □ Pro	
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is in Sign							24a. Wes a			ere autopsy findings
been s should							perion	med?	CC	valiable prior to ompletion of cause
the law requires to the law require to the law been s page 2 should Completed								V-		death?
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certificate rector, page Co	exeminer?	Manufacti	37	1.		of Deeth (C	heck only or	ne)		
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After the funeral fune	27. Menner of Death 1 ☑ Neturel 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time Injury		ijury at Vork?	28d.	Describe h	ow injury occur	red	
Attending or death. ector: After by the fune liftcation	2 Accident investigetic			M 1	☐Yes 2☐					
or Attend after death Director: / d in by the	3 Suicide 6 Could not 4 Homicide determined		At home, ferm, s	treet, fectory, offic	ce ce		Location (Si City or Town		per or Run	al Route Number,
belor Attending P is after death. I Director: After t ed in by the funer Certification:										
To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		d place, end th occurred e	place, end due to the cause(s) end manner es sta occurred et the time, date end place, and due to t			stated. to the cause(s)				
thin thin mplant	29b. Signeture and title of certifier		2	29d. Date signe	d (Month.	Day Year)				
F 3 F 8	1-1-16									
5	Jumes !	16/0000	11/2	שע	1/9			June 22	, 19	19
(5)	30. Name and address of person who									
9	1,/	M.D., 5530 V		n Avenue	, Chev	y Chas	e, Ma	ryland		
State	31. Dete filed (Month, Day, Year)	32. Registrar's S	- /	1	,					
Registrar	JUN 23 199	19 Dineva	D.	poork	2/					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Blaine Reichenbecher 9:20 AM 06 99 19 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Goodwill Mennonite Home Grantsville Garrett Birthplece (State or Foreign Country) If Under 1 Year 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 M 2□ F Months Days Hours Min. Yrs 217-18-4819 80 Sept 4, 1918 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Garrett Maryland Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2540 Pigs Ear Road 21536 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) Auto Mechanic

18. Mother's Name (First, Middle, Maiden Sumame) 12 Automobile Garages 17. Fether's Name (First, Middle, Last) Albert G. Reichenbecher Stella Folk 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Freda Grace Reichenbecher/Wife 2540 Pigs Ear Road, Grantsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Addison Cemetery, June 22, 1999 Addison, PA 21. Signature of Funeral Service Licensee Dooo 80 22. Name end Address of Facility Newman Funeral Homes, P.A. 179 Miller St., P.O. Box 275, Grantsville, MD 21536 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart fellure. List only one ceuse on each line. Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in deeth) Last Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the caues of death? Ren I Failma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Genorar a perose Careland Vosculary Accurately late effect 1 Yes

Was care referred to medical (Check only one) 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 1 Yes 2 No Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Menner of Death 28c. fnjury at Work? 28b. Time of 28d. Describe how injury occurred

Physician /Medical **Examiner**

Examiner Physician/Medical

Physician

/Medical

Examiner

Director

ρ

Be

Funeral

Director

7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examiner must be notilied at

the Maryland

With

death

permit. Peges 1 end 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. If from 27 is marked other than "natural" why injury or other trainment.

Saltimore, Maryland 21215-0020

Box 68760,

Records, P.O.

Division of Vital

iclan end buriel-transit

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Completed

edical

1 2 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

be executed physician s the buriel signed by has To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certification of the funeral director.

State Registrar 29b. Signature end title of certifier Martin

16-CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated.

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

29c. License number 11188620

1 Yes 2 No

29d. Date signed (Month, Day, Yeer)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

Elvin L Martin D.O. 231 Ort St. Salisbury, Pa. 15558

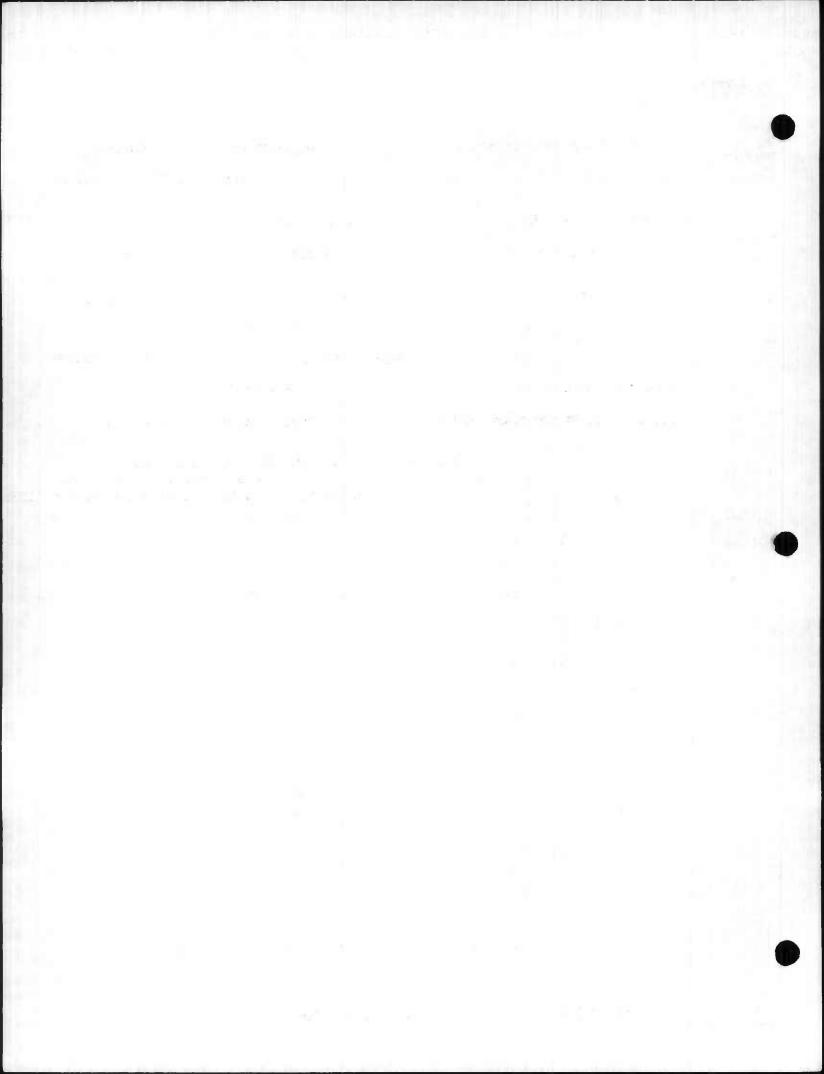
31. Dete filed (Month, Day, Year)

5 Pending

investigation

6 Couid not be determined

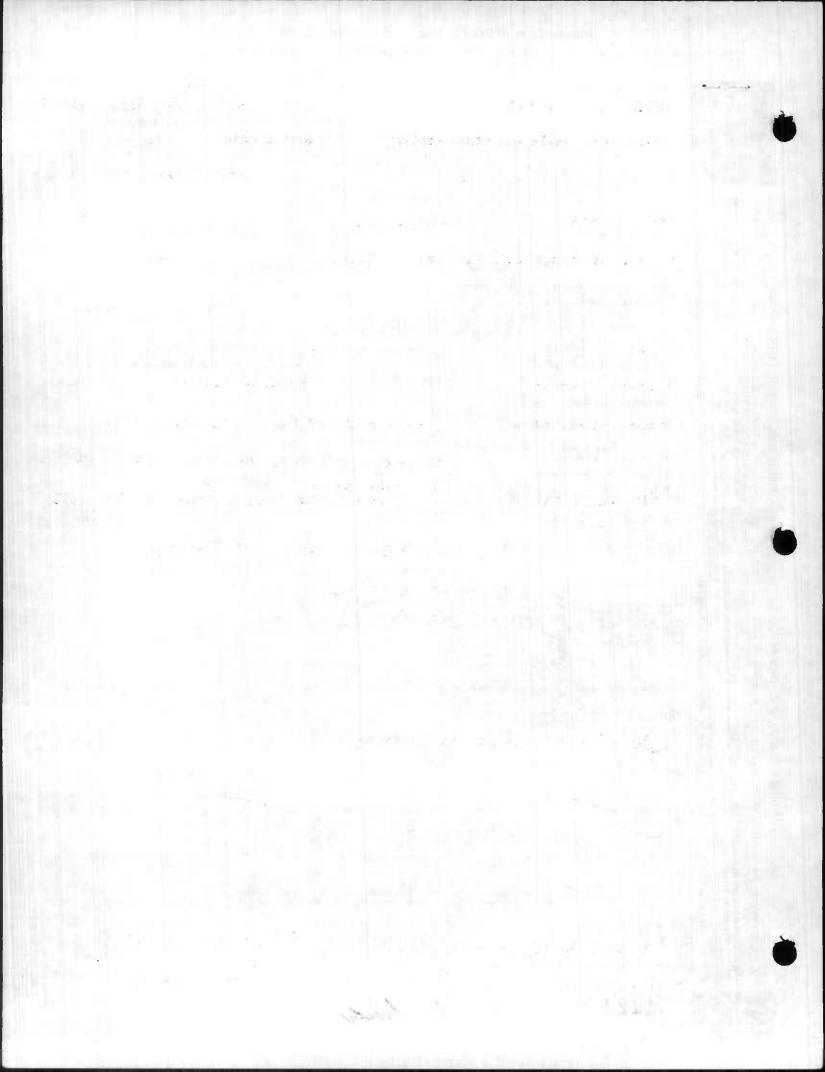
32. Registrer's Signature JUN 2 4 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 21610

						(Certifica	te of	Death			Reg. No.			
Elja - HANDA - 1914, pridekt	ä.	1. Decedent's Name (First,	Middle, La	st)							2. Dete of De	_	Veet	3. Tima	of Deeth
Physicia		DAVID E.	SI	MMONS							June	14 ^{Day}	1999	1:2	5 PM
Medic Examin		4e Facility Neme (If not inst	itution, giv	e street end n	umber)				4b. City, To	own, or L	ocation of Deeth	4c. Co	unty of Deeth		
		Millennium	Heal	th And	Rehab	Cent	er		Gler	Bui	rnie	Но	ward		
Funeral		5. Sociel Security Number	6. 9		7. Age (In y	rs. lest birth	dey) If Und	or 1 Year Devs		24 Hrs.	6. Dete of Birt (Month, De			place (Stete	e or Foreign
Director		241-76-9764 Usual Residence of Decede		M M 2□F	51	Y	s. Months	Deys	Hours	Will.	April 26			Carol:	
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28e	Director	10e. Street end Number			1 4	asmy		ip Code				10g. Citizer	of Whet Cour	ntry?	
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fter fter	Funeral	1 Never Married 2 □	Merrled	Armed F	2 X No						Rican, etc.)		Bleck, White,	etc.	
L'. O	by	3 ☐ Widowed 4 🗓 Div		If Yes, G Year or	ive		1 Tes	2 💢 No	Specify.			Sp	ecify:		
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d be ental	To Be	Hillard S:	mmo	ns					Ber	cnic	e Pric	ce			
d 2 should be file th end Mental Hy 7 is marked othe traumatic avant	-	19a. Informent's Name/Rele				19b.	Maiting Addre	ss (Stree	t and Numb	er or Rui	rel Route Numbe	er, City or To	own, Stete, Zij	Code)	
end 2 seath er n 27 is ver trau											burg,				
_ + 5 5	ŀ	Victoria Go 20a. Method of Disposition	Darii	eaux	201	b. Piece of I	Disposition (N	eme of		TAS	Dete		tion - City or To		
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an e	E	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying		M	1 201.	isof	410	11					1		
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ding P. After funer	on	27. Manner of Death 1 Natural 5 □ P	ending	28e. Dete (Mo	nth, Day Year	28b. Ti	ury	28c. Inju			28d. Describe	now injury o	occurred		
f or Attending efter deeth. Director: After 3 in by the fune	Certification:	E LI Modidorit	vestigation outd not b				М		Yes 2	J No				10	
or Attendi	를		etermined	286. Piec	e of Injury - A ding, etc. (Spe	it home, ferr ecify)	n, street, fecto	ry, office			28f. Location (City or To		Vum <i>ber or Rur</i>	al Houte No	umber,
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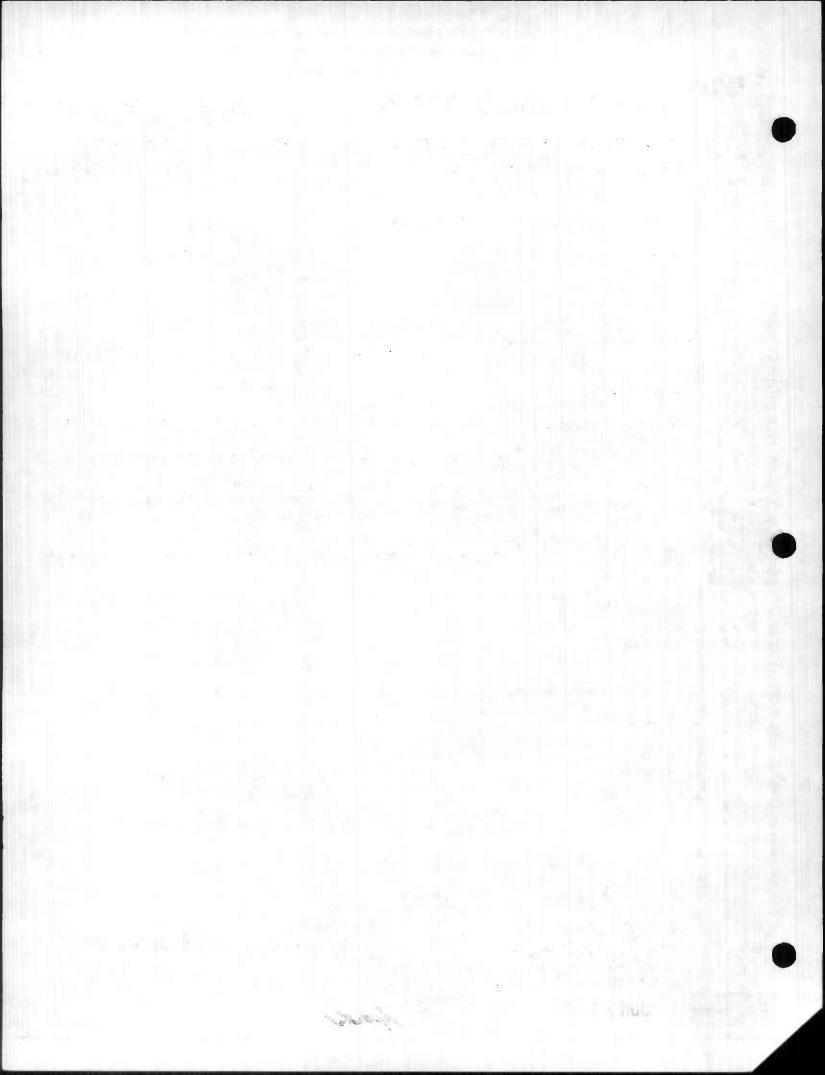
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State of Maryland / Department of Health and Mental Hygiene

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	/Medical Examiner	_	4a Facility Name (If not institution, give	street end number)					4b. City, To	own, or Lo	ocation of Dea	th 4	c. County	of Deeth		
		_	SHADY GROVE AD	VENTIST I	HOSP	ITAL			ROCE	KVTI	LE		MONT	GOME	RY	
	Funeral		5. Social Security Number 6. S	ax 7. Aga		st birthdey)	If Und	er 1 Yaa Deys	r If Under		9 Date of B	ieth		9 Birthol	lace (State or I	Foreign
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	e Me	3	Maryland Montgome	ry	Gait	hersb	urg								1 Ves 2	□ N0
	or 20	5	10e. Street and Number				10f. Z	ip Code				10g. C	itizen of	What Coun	try?	
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21215-0020	should be filed within 72 hours after death with the Maryland of Mental Hygiena. marked other than "natural", or items 23 or 28=4 show imatic event, the Medical Examination and the notified at To Re Completed by Funeral Director.	2	1 ☐ Never Marriad 2 ☐ Married 3 ☐ Widowed 4 🔯 Divorced	1 ☐ Yas 2 ☒ N It Yes, Give Year or Dates:	10		1 ☐ Yes	2 X) No	Specify.				Specif	y: Wh	nite	
5-0	72 hc	2	15. Decedent's Ed (Specify only highest gre	ucetion de completed)		16e. Dece	dent's Us	uel Occi	pation during mos	st of work	ina	16b.	Kind of B	usiness/Ind	lustry	
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yla	2 should be fill end Mental His marked of reumatic even		Robert Dudley						Cora	Edn	a Sowa	sh				
a	end end ls me		19e. Informant's Name/Relationship ('ype, Print)		19b. Maiti	ing Addre	ss (Stree	et end Numb	er or Rur	al Route Num	ber, City	or Town	, Stete, Zip	Code)	
	1 end 1 Health em 27		Jane Fox / Daught	er					allow	Plac	e, New	Mar	ket,	MD 2	1774	
altimore,	of Her	1	20a. Method of Disposition	D	20b. Pie	metery, cre	metory o	eme of other p	ece)		Date	20c.	Location	- City or To	wn, Stete	
Ĕ	Pag nert: H		1 ☐ Burial 2 🖫 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Met	ropo1	itan	Cre	matory	7 06	5/21/99	A1	exan	dria,	Virgin	nia
alti	Death. Pages I end 2 should be filed within 72 ho Department of Health and Mental Hygiena. Important: If them 27 is marked other than "natur may injury or other traumatic event, the Medical bage.	-	21. Signature ot Funeral Service Licen	S66		2	2. Name	end Add	ress of Facili	ity U.	mo D	٨				
B	A E S S		22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate													
Met.		+	23a. Part1. Enter the disease, or com	plicetions that ceused	the deeth.						-	-	.0411	Τ,	Approximete	
	Physician /Medical Examiner		shock, or heart failure. List only Immadiate Cause (Finet disease or condition resulting in death)	· Chro	mi	as e conse			~ P	ul	morary	14	Nea	,	Interval Betwee Onset and De	
	ة السالم	5					,	7.								
	requires that the death certificate be assecuted seen signed by the attending physician end hould be detached for use as the burial-transit eted by Physician/Medical Examiner		Sequentially list conditions.	b	Due to (or	as a conse	quence o	f):								
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Vital	certificata ha rector, page.		25. Wes cese reterred to medical						26. Piac	e ot Deat	th (Check only	one)				
>	Physician: The I this certificeta harral director, page		examiner?	Hospital: 1 Inpatia	nt 2 E	R/Outpetie	nt 3 🗆	DOA	kher: 4 N	ursing Ho	ome 5 Ras	sidence	6 □Ot	her (Specify	y)	
of	g Ph er th neral		27. Manner of Deeth	28e. Date of Injur (Month, Dey		28b. Time o	of	28c. In	ury et		28d. Describe	how In	jury occu	rred		
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Division	tal or Attending P rs after death. al Director: After t led in by the funera		3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc			reet, fect	ory, offic	a		281. Location City or To			ber or Rura	il Route Numbe	er,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral Medical Certification:			yelclan: To the best of ntner: On the basis of and manner sta	exemineti											
	ithin on the omple		29b. Signature and title of cartifies	1 1	. *		2	9c. Lice	nsa number			29d. [Data sign	ed (Month,	Day, Year)	
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1 16 Rev 6/95



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	Usual Residence of Decedent		I 10: 0it.	Taxan and another						
5	10a. Stata 10b. County			Town or Location		C			1	0d. Inside City Limits 1 Yas 2 No
rect	10e. Street and Number		was	hingto	. Zip Code	.		10g. Citizen of V	Vhat Coun	try?
O P	3601 Wise Ave	. N.W.			2001	.6		United	d St	ates
Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces 1 Yes 2	?	If Yas,	ecedant of h specify Cub	dispanic Origin? an, Mexican, Pue Specify:	Specify Yes or No irto Rican, atc.)	Blac	k, White,	
d by	3 ☑ Widowed 4 ☐ Divorced	Yaar or Datas:						Specify	1411	ite
Completed	15. Decedent's l (Specify only highest g	Educetion rade completed)		16e. Decedent's (Give kind of life, DO No	Usual Occup of work done OT use retire	dunna most of w	orking	16b, Kind of Bu	isiness/Inc	dustry
mo	Elementary/Secondary (0-12)	College (1-4or	5+)		s Per			Reta	il S	ales
o Be C	17. Father's Name (First, Middle, Las Michael Cohe						ie Cohe		e)	
	19e. Informant's Neme/Relationship						Rurel Route Numb			
	Elaine Scheer	/Niece								C. 20015
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	1001-10	12.1	2				Stein	Funer		
	23a. Part1. Enter the disease, or conshock, or heert failure. List and	mptication that cause	the death.						con,	DC 20012 Approximate
n	shock, or heart failure. List onl	y one gadse on each	ine.						i	Intervel Between Onset and Death
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	resulting in death)	w	Due to (or a	s e consequenc	of):				1	
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Physician/M	Part II. Other eignificant conditione				ing ceuse gi	ven in Part I.		tobacco uae coi		the cause of death?
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Completed t							24a. Was perfe	an autopsy ormed?	av	are autopsy findings allable prior to mpletion of ceuse death?
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inol.	27. Manner of Deeth 1 Netural 5 ☐ Pending	28e. Dete of Inj (Month, D	By Year)	8b. Time of Injury M	28c. Inju Wo	ry et rk?]Yes 2 □ No	28d. Describe	how injury occur	red	
	2 Accident Investigation 3 Suicide 6 Could not	be One Disco of In	iury - At hom	e, farm, street, fa		1165 2010	28f. Location (Street and Numb	er or Rura	al Route Number,
ficat	4 ☐ HomicIde determine	building, e	tc. (Specify)	-,,			City or To			
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dical Certification:		miner: On the basis of								
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Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 21613

			Certifica	ite of	Death		Reg. No.		
1. Decedant's Nama (First, Middla, La	ast)					2. Date of D	eath Day	Vear	3. Tima of Death
Paul Thompson	Sembower,	Sr.				JUNE		, 1999	0714
4a Facility Nama (If not institution, gir	ve street and number)				4b. City, Town,	, or Location of Dea		inty of Death	1
3155 QUE	ENS CHAP	PEL 1	ROAP A	PTDI	MOUNT	RANIER	PRI	NCE GE	orges
	Sax 7. Age (n yrs. last bir	Month:	er 1 Yaar s Days	If Undar 24 Hours		irth Day, Year)	9. Birth	olaca (Stata or Foraign
234-30-8517	7 TAIM 20 F	4	Yrs.			Dec.	14, 192	25 Virg	inia
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72. 22.									1 X Yes 2 □ No
Maryland Prince (George's	Mount	Rainie						
10e. Street and Number				ip Coda				of What Cou	ntry?
3155 Queens Chap				0737			U.S.A		
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James Thompson S									
		401-	A 4 - 12 - A 4 4	(0)		Elizabet			0-4-1
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1 Burial 2 □ Cramation 3 [cemeter	y, cramatory of	r othar pla	,				
4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Lice		Fort 1	Lincoln	Ceme	etery	06/25/99	Brent	wood, l	Maryland
Sequantially list conditions, if any, leading to Immediate causa. Enlar Undarfying Ceusa (Disaesa or injury that initiated evants rasulting in death) Last	С.		consaquanca o					1	
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Part il. Other significant conditions	contributing to death but r	ot rasulting In	tha undariying	causa gh	van in Part i.	23b. DI	d tobacco us	contribute t	o the causs of death
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axaminar?	Hospital:	• C E D (0)	anational OF	DOA Ott	ner.	Death (Chack only		Other (Case	4.1
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2 Accident invastigation 3 Suicide 6 Could not be determined	De Dines of Injury	- At homa, fa	rm, straat, fact	ory, offica		28f. Location	(Straat and Nown, Stata)	lum <i>ber</i> o <i>r Rui</i>	a <i>l R</i> outa Num <i>ber</i> ,
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	and mannar states								
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(Check only 25 Madical Example only 29b. Signature and title of certifier	A LOUIS	h (Itam 23a)		P Z	sa number 3954		29d. Dete s		Day, Year)
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A TOTAL CONTRACT OF THE PARTY O

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** CATHERN BURMA LAWRENCE SOUTH 1999 JUNE 24 10:10 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES COUNTY NURSING HOME LA PLATA
If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) Date of Birth (Month, Dev. Year) **Funeral** Deys Hours Min 1□ M 20 F Yrs. Director 212-54-6923 86 NOV 14 1912 West Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ? le marked other than "natural", or flems 23s or 28a-f show treumstic event, the Medical Examiner must be notified at 1 ¥ Yes 2 □ No Directo Maryland Charles La Plata 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with 10200 La Plata Road 20646 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiena.
nt: If them 27 te marked other than "natural", or thems 23. Funeral USA 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No It Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Marital Status 1 ☐ Yes 2♥ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) House Wife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 86 0 F. Lee Lawrence Myrtle Jewell Lawrence 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Ross J. South (son) 12801 Jones Lane Waldorf, MD 20602 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Operation 5 Other (Specify) permit. Pages Department of Important: If it any injury or o Oakland Cemetery Waldorf, MD 6-28-99 21. Signatura of Famaral Service Licenses 22. Name end Address of Fecility J.H. Eberwein Mortuary

4433 White Pls 1a White Pls., MD 20695
Approximate enter the mode of dying, such as cerdiac or respiretory errest, Interval Between Onset and Death M00173 23a Ply Enter the disease, or complications that caused the death. Do not enter the disease, or heart tailure. List only one cause on each line. **Physician** /Medical immediate Cause (Final disease or condition resulting in death) Examiner DNEUMONIA Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and attending physician for use as the buria Box 68760. Physician/Medical thet initiated events resulting In death) Last Due to (or as a consequence of) P.O. ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Whitnown Division of Vital Records, þ 24b. Were eutopsy tindings evallable prior to completion of ceuse of death? 24e. Wes en eutopsy periormed? Completed been s certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician:
24 hours after death.
 Funeral Director: After this certifical. funeral director, 25. Was cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Naturai 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es steled.

2 Medical Examinar: On the basis of examinetion and/or investigetion, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) within 2 29b. Signature and fitte of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

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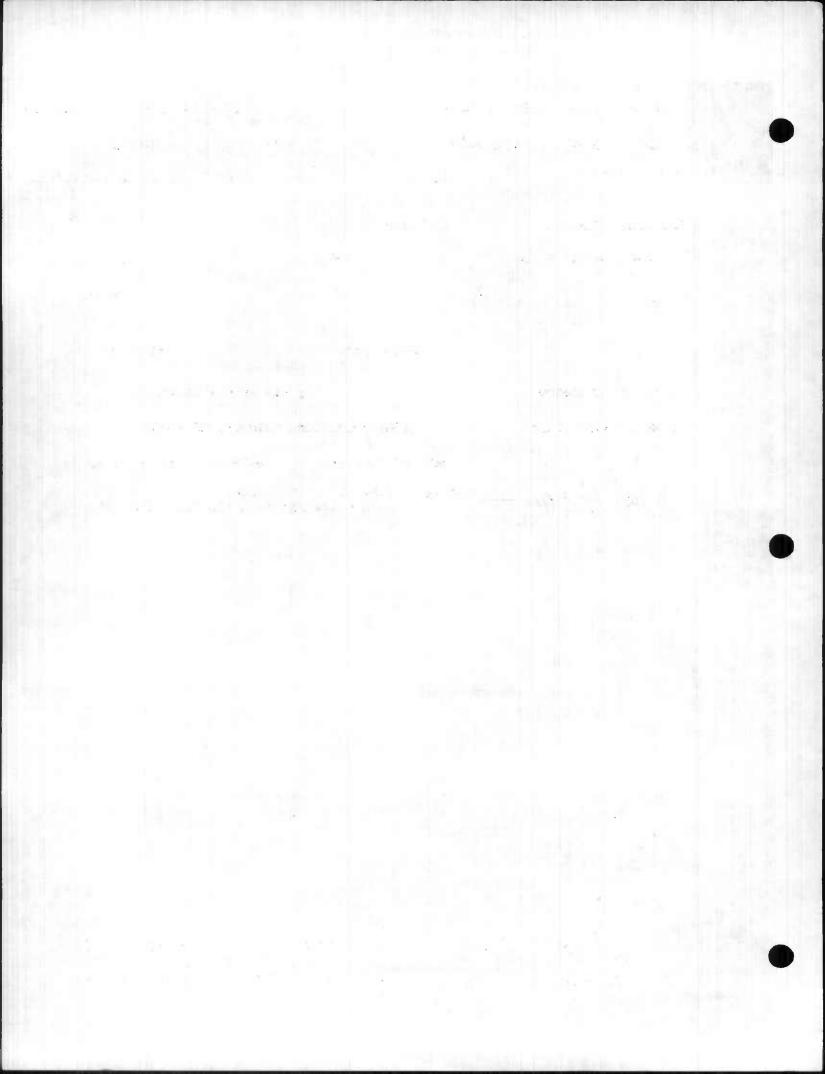
woystain DR WANDSEFMO 20602

State Registrar 31. Date tiled (Month, Day, Yeer)

JUN 2 8 1999

30 Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

32. Registrer's Signeture



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) 3. Tima of Death Month **JEROME** SALKIN JUNE 21, 1999 6:40 AM 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not Institution, give street and number) HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY 8. Sex 1 M 2 □ F 7. Age (In yrs. lest birthday) If Under 1 Yeer If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) Deys Hours 225-10-0070 OCT. 13, 1908 MARYLAND Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No ALEXANDRIA 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 22303 UNITED STATES 901 ALLISON STREET 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 1 Tyes 2 No If Yes, Give Yeer or Detes: ↓ 1 Never Merried 2 Merried 1 Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced WW II 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mothar's Neme (First, Middle, Meiden Surmama) MERCHANT 17. Fether's Nama (First, Middla, Last) RAYMOND SALKIN TILLIE MAULITZ 19a. Informent's Nema/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stata, Zip Code) 3412 ALABAMA AVENUE ALEXANDRIA VA 22305 MARILYN M. DAVIS (NIECE) 20b. Pleca of Disposition (Name of cametery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurlal 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING DAVID MEMORIAL GARDEN 6/22/99 FALLS CHURCH VA 21. Signeture of Fungra Service Licensee 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPEL -1170 ROCKVILLE PIKE ROCKVILLE MARYLAND 20852 Efter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, or heer failure. List only one ceuse on each line. Approximete Intarval Between Onset end Deeth Immedieta Ceusa (Finel disease or condition rasulting in daath) CEBRAL ISCHEMIA ARTERIO SCLEROSIS GENERALIZED Due to (or es e consaquance of): DIABETES Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

end I-transit

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b Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica etely lilled in by the funeral director, I

• Funeral f

To the

within 24 hou To the Funer completely lil

that the death certificate be axecuted

Box 68760.

Division of Vital Records, P.O.

Examiner

Physician/Medical

Completed

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Physician

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Examiner

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Director

"naturel", or itema 23a or

permit. Pages 1 end 2 should be filed within 72 hours after death v Depertment of Health end Mental Hygiene. Important: If item 27 is marked other than "naturel", or itema 23a amp injury or other treumetic event, tha Med cal Examiner must bonce.

Baltimore, Maryland 21215-0020

with the Manylend r 28a-f show

> Sequentially list conditions, if eny, laading to immadiata cause. Enter Underlying Ceuse (Disease or Injury that initiated avants resulting in death) Lest

CORONALY ARTERY MALNUTRITION DECUBITUS

24e. Was en autopsy

24b. Were eutopsy findings available prior to completion of cause of deeth?

1 Yes 2 No 28. Placa of Daath (Check only ona)

1 Yes 2 No

25. Wes case referred to medical exeminer? 1 Yes 2 No

5 Pending investigetion

6 Could not be detarmined

28e. Deta of Injury (Month, Dey Year)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28f. Location (Streat and Number or Rural Route Number, City or Town, Stete)

29a. Certifian

27. Manner of Deeth

1 Neturel

2 Accident

3 Suicide

4 Homicida

18 Certifying Physician: To the best of my knowledga, deeth occurred at the tima, data and placa, end due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daeth occurred at the tima, data and place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier

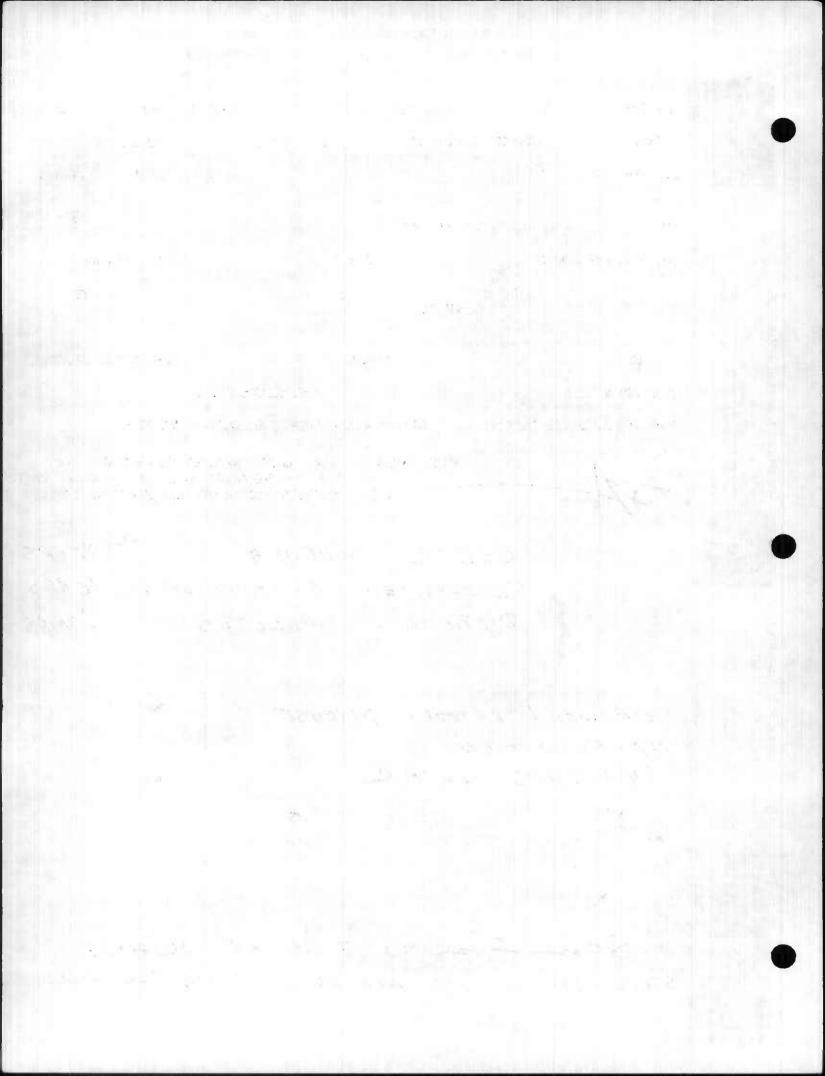
29c. License number D 05885 29d. Dete signed (Month, Dey, Year)

30. Name end eddress of person who complated causa of deeth (Item 23e) (Type, Print)

6121 MONTROSE ROAD, ROCKVILLE STEVEN LIPSON

State Registrar 31. Deta filed (Month, Dey, Year) JUN 22 1999 32. Registrer's Signeture

B. Sports



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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OSEPH	State	e of Maryland / Department of Health and N F PER MEO G773 Certificate of Death	Mental Hygiene	101
ANDERS	TEMS: #23 PART I, II, 27, 28A-	F PER MEO G773 Certificate of Death	Reg. No.	101
	1. Decedent's Neme (First, Middle, Last)		2. Date of Death	3. Time of [
Physicia	Incorb Ismos	Candana III	JUNE 17, 1999	8:45P

Examiner

Funeral Director

258-7 # ò Berrs 23a s filed within 72 hours after of if Hygiens. other than "natural", or liter

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other treuments event.

Maryland 21215-0020

Baltimore.

Physician /Medical Examiner physician s the burial Box 68760,

that the death certificate be executed 980 been signe should be page or Attending Physician: director, this funeral After 24 hours after death. Puneral Director: A 3 filled in Hospital completely within 2 a ta 0

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Records,

of Vital

Division

Death .M. Joseph James Sanders, III 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 5527 HALPINE PLACE ROCKVILLE MONTGOMERY 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 1 X M 2 □ F Hours June 3, 1954 220-60-3203 45 Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 💢 No Director Maryland Montgomery Rockville 10g. Citizen of What Country? 10a. Street and Number 10f. Zip Code 5527A Halpine Place 20851 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? t ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: P 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Alcoholics Elementery/Secondary (0-12) College (1-4or 5+) 12 Anonymous Facility Night Manager 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Blanche Keys Joseph James Sanders, Jr. 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline E. Sanders/sister 1803 McAuliffe Drive, Rockville, Maryland 20851 20b. Place of Disposition (Name of cemetery, crematory or other place) June 20, 1999 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 1 Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signeture of Funeral Service Licensee 22. Neme and Address of Fecility Robert A. Pumphrey Funeral Home/Rockville, Inc. West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feliure. List only one cause on each line. Approximate Intervel Between Onset and Deeth Immediate Cause (Final disease or condition resulting in deeth) NARCOTIC INTOXICATION Due to (or as a consequence of): Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown CIRRHOSIS by 24b. Were autopsy tindings available prior to completion of cause of death? Be Completed 24a. Was an autopsy MORBID OBESITY 1 Yes 2 □ No 1.2 Yes 2□ No 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5XX tesidence 6 Other (Specify) 1 X Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) Found: 6-17-99 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Р 1 Netural 5 Panding Found: 1 ☐ Yes 2 ☐ No UNKNOWN investigetion 2 Accident 8:30 8 🖾 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, etreet, fectory, office building, etc. (Specify)
FOUND AT HOME 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5527 HALPINE PLACE 4 Homicide ROCKVILLE, MARYLAND 29e. Certifier 1 Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner es stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and menner steted. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) tomo O.C.M.E. JUNE 18, 1999 30. Nama and address of person who completed cause of death (Item 200) (Type, Print) Radentz, 111 Penn Street, Baltimore, Maryland 21201 Stephen 31. Dete filed (Month, Day, Year) 32. Registrer's Signature

DHMH 16 Rav 6/95

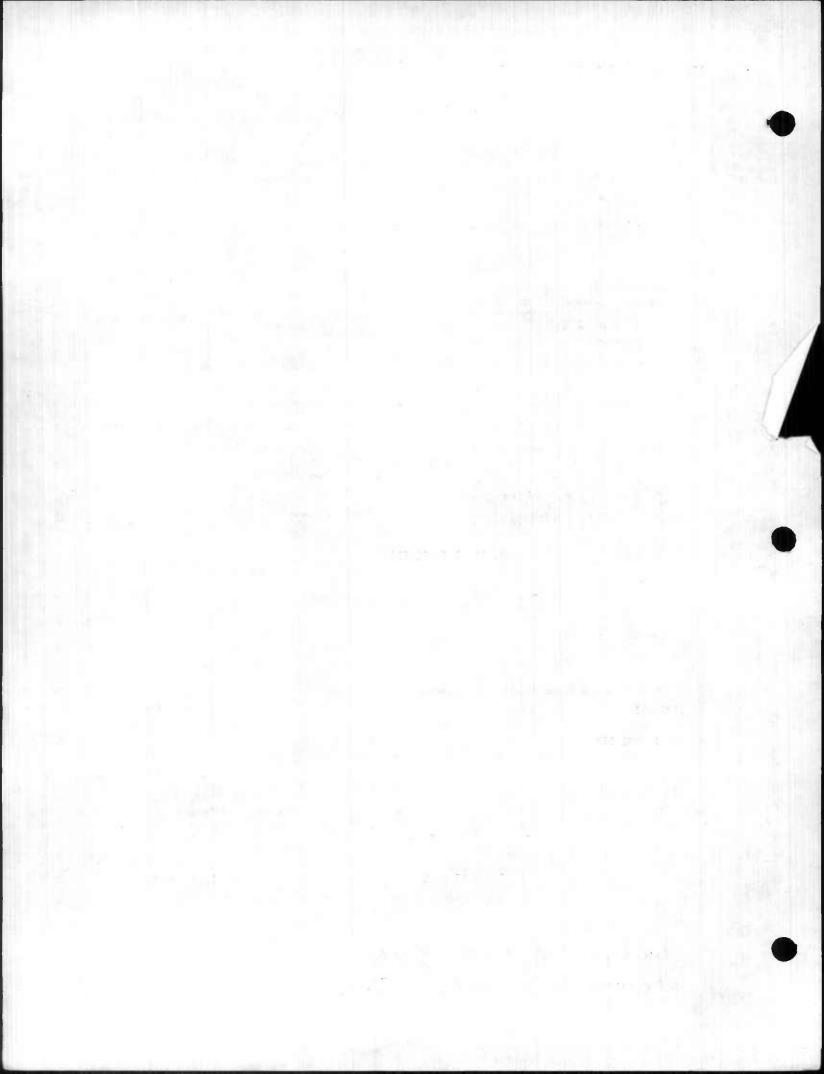
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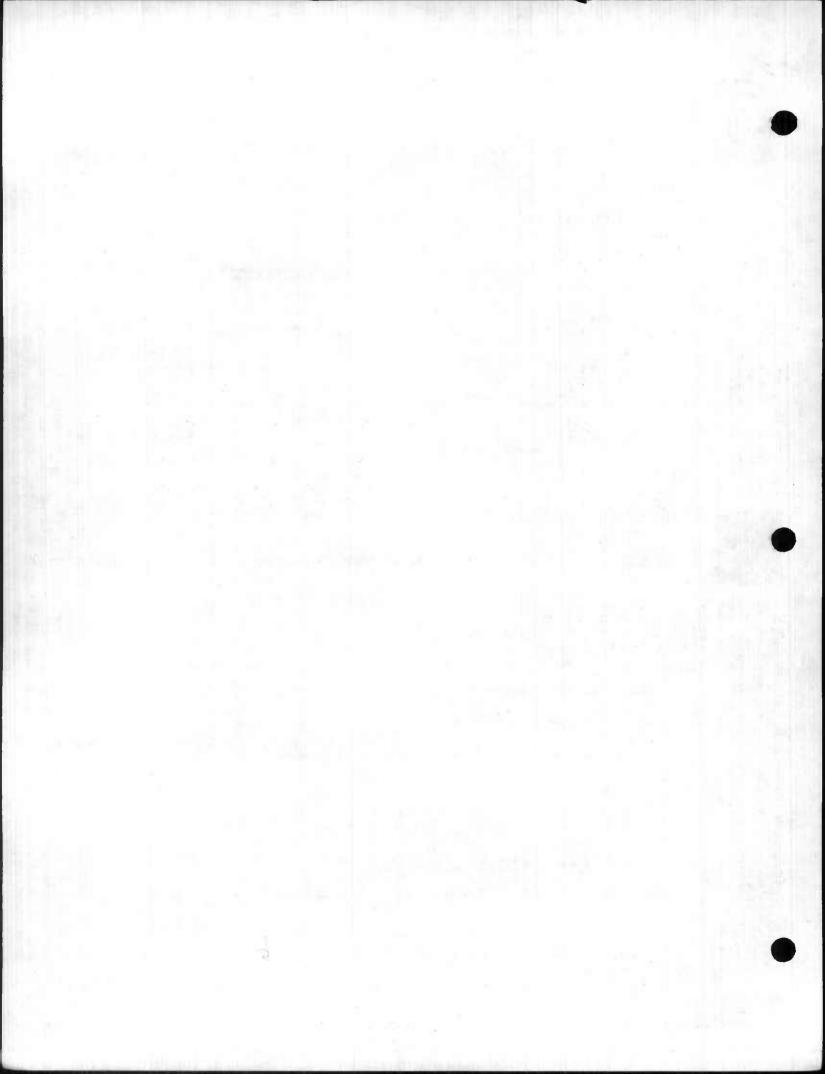
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State of Maryland / Department of Health and Mental Hygiene

				Otate of N	nai yiaila / i	Certifica		Death	ionai i iy	Reg. No.	9 2	1617
	Dharaini		me (First, Middle, Las	st)					2. Date of De Month		Year	3. Time of Death
	Physician /Medical	KINGER H	SAWTELLE							21, 1999		9:45 P.M.
	Examiner	An English Mains	(If not institution, give	street and number	r)			4b. City, Town, or L	ocation of Deat	h 4c. Count	y of Death	
			PERT ROAD					SILVER SP			COMERY	
	Funeral Director	5. Social Security 579-26-4 Usual Residence	380	9x 7. A	Age (In yrs. last bii 72	Yrs. Month:	er 1 Year s Days		8. Date of Bir (Month, Da OCT • 1	th Year)	9. Birthple Country MASS	ace (State or Foreign ry) ACHUSETTS
	E 8 11	10a. State	10b. County		10c. City, Tow	n or Location					10	Od. Inside City Limits
	with the Maryland a or 28s-f show be notified at Director	MARYLAND	MONTGOME	RY	SILVER	SPRING						1 ☐ Yes ¾IXNo
	or 28s-f s be notified	10e. Street and No			10	1	ip Code		I	10g. Citizen of	What Counti	ry?
	238 c		PERT ROAD			20	903			UNITED	STATE	S
	8 29	11. Marital Status		12. Was Deceden	t Ever in U,S.			Hispanic Origin? (Sp van, Mexican, Puerto	ecify Yes or No	- 14. Ra	ce - America	
20	hours shar hursi', or its at Examina of hy Fu		ried 2XXMarried	1 XIX es 2 I	1945-			Specify:		Specia	fv:	
8	hour hour		4 ☐ Divorced	Year or Dates	1940	. Decedent's Us	ual Occur	netion		16b. Kind of B		ITE
21215-0020	ad within 72 ho typiane. wer than "naturn it, the Medical	(Spe	cify only highest gra	de completed)		(Giva kind of w life. DO NOT	vork done	during most of work	ing	160. Kind of E	USINGSS/INCL	patry
212	dividing	Elementary/Sec	2	College (1-4o		ESIDENT				RETAIL	BICYC	LE
P	tal Hyg d other event,		(First, Middle, Last)					18. Mother's Nam	e (First, Middle	, Maiden Sumai	me)	
/an	Wents Ments Me ed		. SAWTELL	E				EMILY H.	HOAG			
Maryland	and and and and and and and and and and	19a. Informant's N	lame/Relationship (7	Type, Print)				t and Number or Rur				
	and ealth 127 ter tr		I. SAWTEL	LE - WIFE				ROAD, SIL				
0	Pages 1 net: If har iry or off	20a. Method of Dis	sposition	Removal from State	comete	d Disposition (N ry, crematory or	ame of other pla	ice)	Date	20c. Location	- City or Tow	vn, State
Ë	2	4 Donation	5 DOther (Specify)		1		CEMETERY	6-25-9	9 ADELP	HI, M	ARYLAND
Baltimore,	Semil Separt mport my inj	21. Signature of F	uneral Service Lieun	500				ess of Facility ALDI FUNER	AT. HOME	E. TNC.		
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	/Medical Examiner property of the property of	Immediate Cause disease or conditi- resulting in death)	on	a. <u>Me</u> ;	Dua to (or as a	consequence of	f):	Cerunen	ne			Le mintels
×	physicia the bur	Cause (Disease o that initiated even resulting in death)	IS The state of th	cd.	Dua to (or as a	consequence of):				1	
	he attended for u	Part It. Other signi	ificant conditions or	entributing to death	but not resulting i	n the underlying	cause gi	iven in Part t.	23b. Did	tobacco use co	ontribute to	the cause of death?
Ω.	P 00	1	rkinser	is Du	cose				10	Yes 2□No	3 Prob	ably Shriknown
of Vital Records,	S * 0 D	Co	Mulet	ryh	t arm					s an autopsy ormed?	con	ra autopsy findings illable prior to appletion of cause leath?
E .	Physician: The law this certificate has be all director, page 2 s. To Be Combil.								10	Yes 22No	10	Yas PHO
<u> </u>	olen Settifi Be		The contract of	Hospital:			10	26. Place of Deal	h (Check only	one)		
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	Affect Af	1 SPatural 2 ☐ Accident	5 Pending investigation	(Month, D		Injury	28c. Inju Wo	rk?]Yes 2□No	200. 0000100	now injury cocci	1160	
	be or Attending Physics after death. If Director: After this ed in by the funeral di	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Ir	njury - At home, fa atc. (Specify)	arm, street, facto	ory, office			(Street and Num	ber or Rural	Route Number,
	To the Hospital or Att within 24 hours after of To the Funerel Direct complataly filled in by Medical Certifi				of examination an			ima, date and place, opinion, death occur				
	within To the	29b. Signature and	title of certifier	/		2	9c. Licen	se number		29d. Date sign	ed (Month, E	Day, Year)
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #1, #5, 7/2/99, BMW, Montg. Co Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Cerardus Hendricus Smittenaar **Physician** 8:31am 20, 1999 JUNE /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 112 PIPING ROCK DR. SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 261-56-55846 10 M 2 F Yrs. Director 68 6, 1930 NETHERLANDS **Usual Residence of Decedent** the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MONTGOMERY MD SILVER SPRING 1 Yes 2 No Director 28a-f 10e. Street and Number 112 PIPING ROCK DRIVE 10f. Zip Code 10g. Citizen of What Country? must be n 20905 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: WHITE Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ELECTRONICS ENGINEER COMPUTERS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fin ment of Health and Mental H lant: If them 27 is marked oth lury or other traumatic even 88 HENDRICUS van KESTEREN GERRITJE SMITTENAAR 19a. Informant's Name/Relationship (Type, Print) 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 PIPING ROCK DRIVE SILVER SPRING, MD 20905 JANTINA SMITTENAAR (SPOUSE) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) PARK LAWN MEMORIAL PARK 6-24-99 ROCKVILLE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHINES-RINALDI 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MARYLAND 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart tailure. List only one cause on each line. Approximata Intervai Between Onset and Daath **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) ARTEROSCLEROTIC HEART DISEASE Examiner Due to (or as a consequence of): Examiner sician and bunial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the Due to (or as a consequence of) USB 85 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? P.O. à 1 Yea 2 No 3 Probably 4 Unknown **ASTHMA** 8 Records, þ De 24b. Were autopsy tindings available prior to Completed 24a. Was en autopsy performed? SLEEP APNEA completion of cause of death? page 2 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No of Vital Attending Physician: funeral director. 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 TNo 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Division 1 Natural 5 Pending investigation death. 1 TYes 2 □ No 2 Accident 24 hours after deal Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Plece of tnjury - At home, farm, street, tactory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 T Homicide 6 Hospital edical 🕰-Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. \$ 29b. Signature and littly of certify 29c. License number 29d. Date signed (Month, Day, Year) 2

State Registrar

DHMH 16 Rev 6/95

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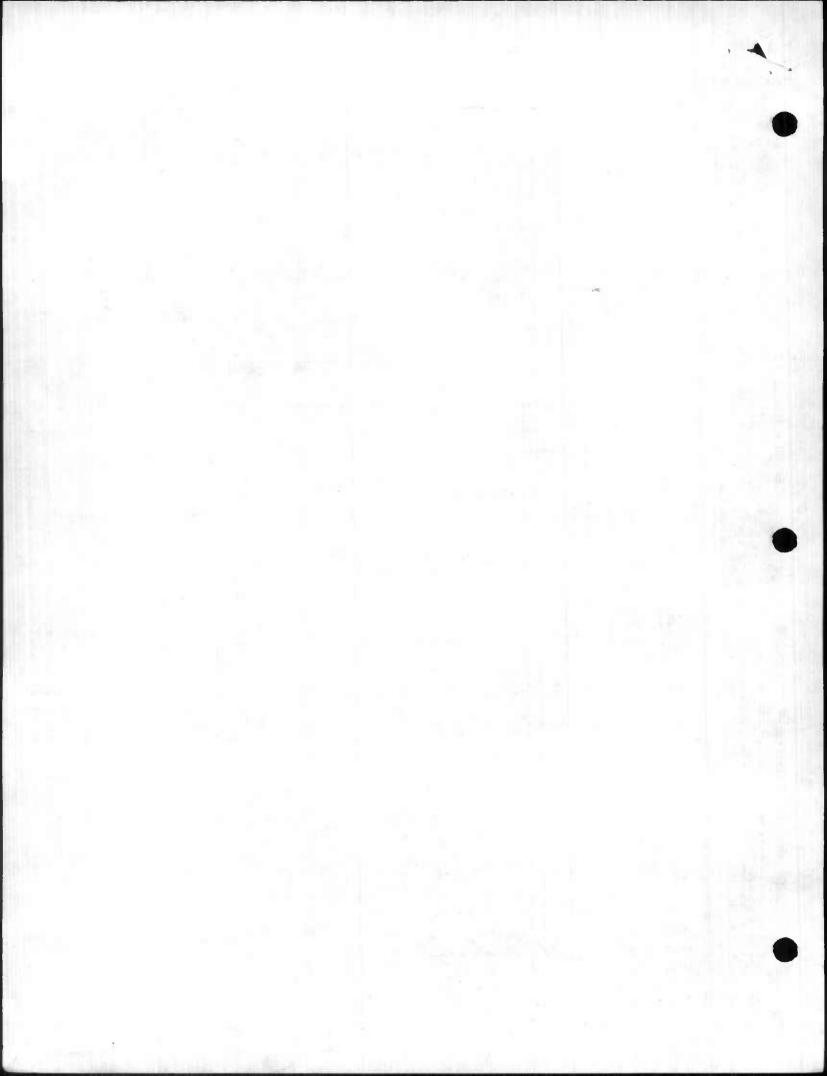
30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

ALAN DIAMOND M.D. 10801 LOCKWOOD DRIVE SILVER SPRING, MD 20901

D24245

6-22-99

31. Date tiled (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day JUNE 15 1999 10:45 AM David rensen 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOPKINS ALT IMOLE CIT TAL If Under 1 Year JUHNS 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months t√ M 2□ F 217-60-6455 Yrs. 45 NOV. WASH. D.C. Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 15 Yes 2 □ No MD. PRINCE GEORGES BOWIE 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 12140 LONG RIDGE LA. 20715 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 Yes 2 No if Yes, Give Year or Dates: 1 Never Merried 2 Merried 1 ☐ Yes 2 ☒ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 TRUCK DRIVER TRUCKING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) VINCENT SORENSEN A. MARGARET O'HARA 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET SORENSEN/MOTHER SAME AS ITEM #10 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 6/21/99 CHAMBERS CREMATORY RIVERDALE. MD. 21. Signeture of Funeral Service Commen 22. Name and Address of Fecility CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, M00091 MD. 20737 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Finel disease or condition resulting in deeth) Adult Respiratory week Due to (or es a consequence of): Adenovirus week Infecti Due to (or es e consequence of): Due to (or es a consequence of)

Physician /Medical Examiner

burial-transit

signed by the at d be detached for

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After

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completely

To the Hospital or Attendir within 24 hours after deeth. To the Funeral Director: Af

The law requires that the death certificate be executed

Box 68760,

P.O.

Records.

Division of Vital or Attending Physician: Physician/Medical Examiner

Completed by

Be

Certification: To

Medical

Physician

/Medical

Examiner

Directo

Funeral

Completed

88

Funeral

Director

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28a-f

23a or

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the Maryland

filed within 72 hours after

Pages 1 and 2 should be nent of Health and Mental

is marked c

nt of Health a t: If Hem 27 is cor other trau

permit. Page Department of Important: If any Injury or

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

25. Wes case referred to medical

W. Bowerfind MD

1 Yes 2 No

27. Menner of Death

1 Natural

2 Accident

3 Suicide

4 Homlcide

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Disease

28e. Place of Injury At home, farm, street, factory, office building, etc. (Specify)

Pert II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital: 1 Inpatient

28a. Dete of tnjury (Month, Day Year)

Johns Hopkins Hospital

24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed?

1 Yes 2 No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

1 Yes 2 No

KF5-000

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end It is of annual

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

June 16, 1999 Tower 110, 600 N. Wolfe Street Baltimore 21205

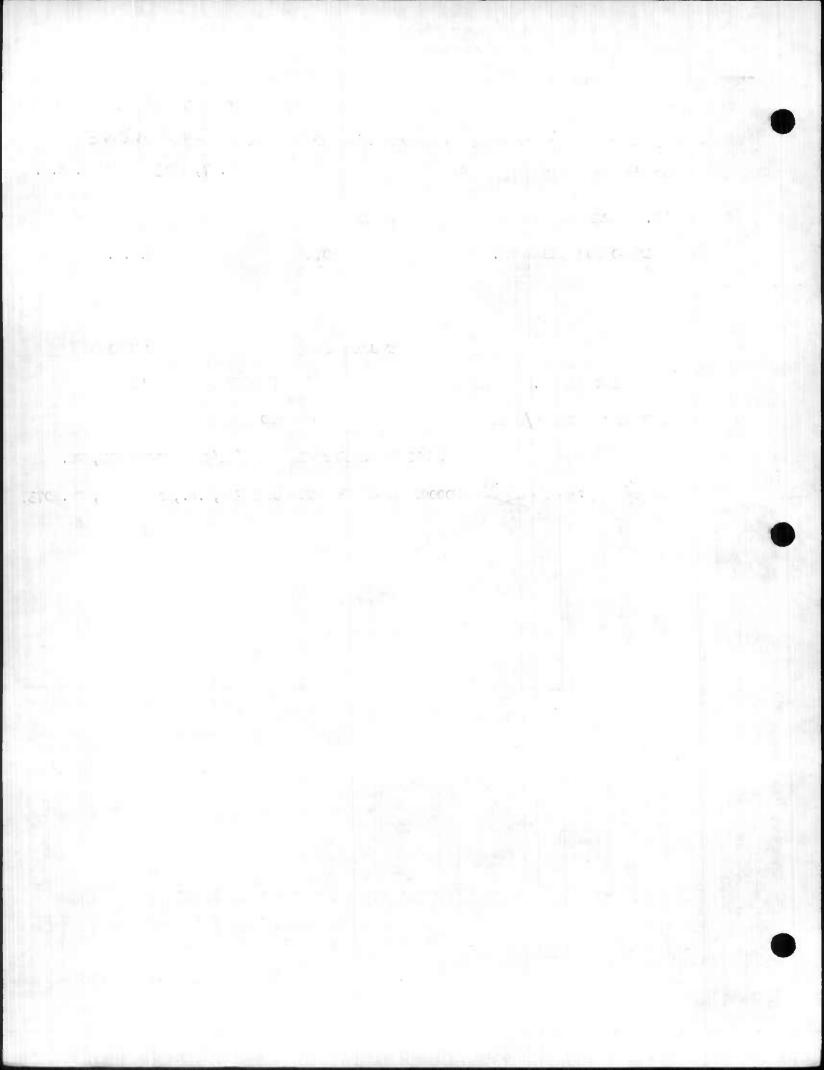
31. Date filed (Month, Dey, Year) State Registrar

JUN 21 1999

5 Pending Investigation

6 ☐ Could not be determined

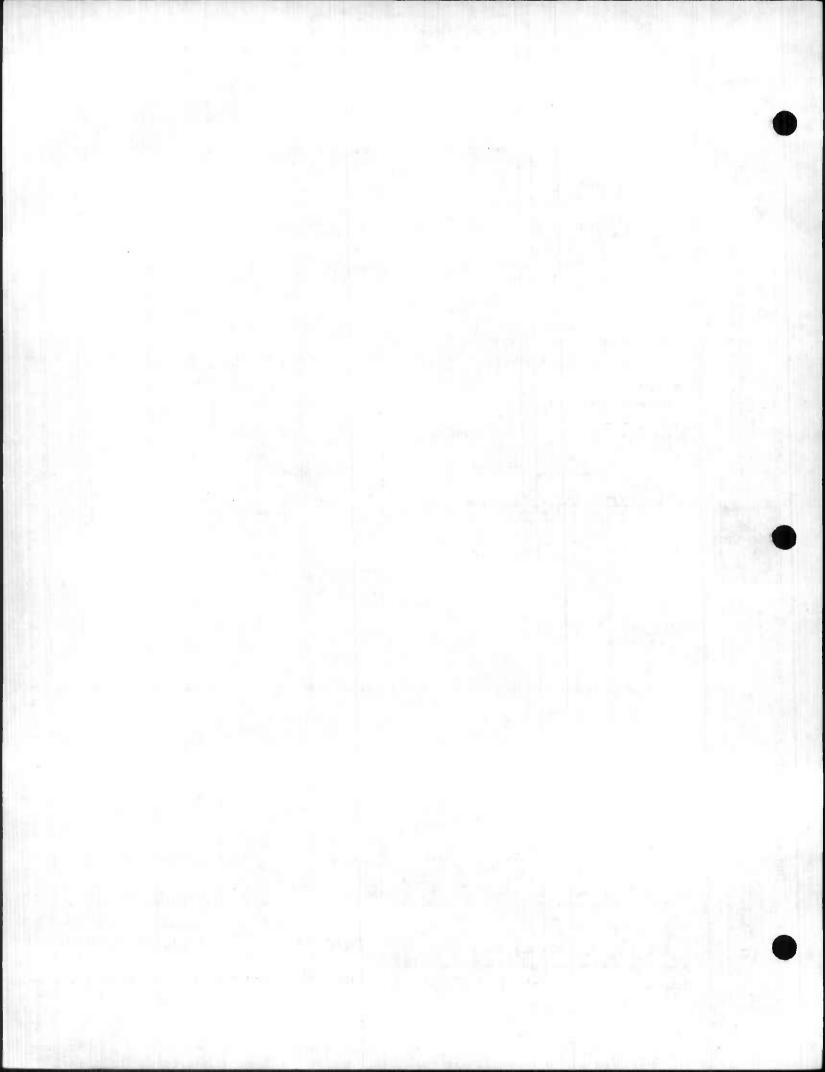
32. Registrar's Signature oaks



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State of Maryland / Department of Health and Mental Hygiene

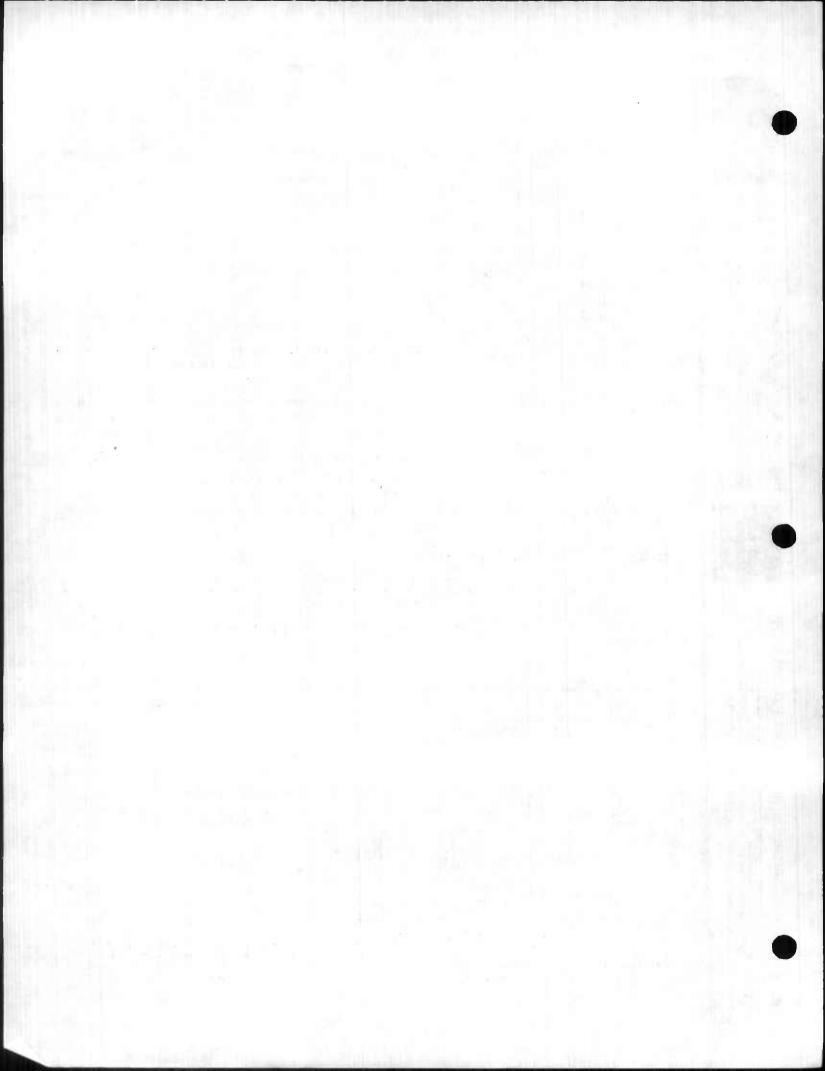
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	Examine	4- 5-	acility Neme (#	not institution, gi	ve street and number)				4b. City, Town, or	Location of Deat	4c. County		
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	6 8	100.3	Street and Num						ip Code			10g. Citizen of V		
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21215-0020	ar.	1[arital Status □ Never Marrie ☑Widowed 4	d 2 Married	12. Wes Decedent Armed Forces 1 Yes 2 X If Yes, Give Year or Detes:	? I No	5. 1	3. Wes Dec If Yes, sp		dispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	Specify	a - America k, Whita, a Whi	itc.
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	/Medical Examiner	result	ediate Cause (F ise or condition ting in death)	inal	a. Pneumor	Later 1	as a cons	sequence of):	7				
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P.O. Box 68	E 000 .	Part II	ing in death) L	ast	d	Due to (or	as e cons	equence or						
m.	death of for	Part !!	. Other signific	ant conditions	contributing to death	but not resu	Itina In the	undertvina	cause oi	ven in Pert I.	23b. Dld	tobacco une co	ntribute to	the cause of death?
Ö	the soh											Yea 2 No	3 Prob	
	de de		Dementi	.a								X		
Records,	The law requires that the death certific tate has been signed by the attending p page 2 should be detached for use as										24a. Was	an autopsy ormed?	ava	re eutopsy findings illabla prior to appletion of cause teath?
	Physician: The law rthis certificate has rel director, page 2.	5									10	Yes 2 No		Yes 21 No
Division of Vital		25 14	as casa referre	d to medical						DE Diagratio				222110
5	certific		caminer?		Hospital:				. Ot	her:	eth (Check only			
ō	Attending Physician: or death. ector: After this certific by the funeral director,		☐ Yes 2反 N anner of Death	10	1 Inpat		:P/Outpat 28b. Tima	ient 3 🗆 🖸	M	4 XI Nursing	Home 5 ☐ Resi	how injury occur		")
5	is after death. In Director: After the Ind In by the funeral	11	Netural	5 Pending	(Month, Di	ay Year)	Injury		28c. Inju Wo	rk?` Yes 2 □ No	EBG. DOSGROO	now injury occur	60	
5	tor:	3	☐ Accident ☐ Suicide	investigation						1165 2 160	204 Location /	Ctract and Alumb	or or Dum	I Pouto Alumbas
₹	frec lin by	4	Homicide	detarmined	288. Piece of in	itc. (Specify	me, tarm,	street, tecto	ry, office		City or To	Street and Numb wn, Stata)	er or Mure	House Number,
•	le le le le le le le le le le le le le l	3	10000											
	To the Hooptal or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral and a second seco	29a.	Certifier (Check only 2 one)	Certifying Pf	nysician: To the best miner: On the basis of end manner s	of examineti	riedge, de on and/or	ath occurre invastigatio	d at the ti	me, data end plac opinion, death occ	e, and due to tha curred at tha tima,	causa(s) and ma data and place,	nnar as st and dua to	ated. tha causa(s)
	To the Tour Common		Signature and ti	tle of certifier		1		2	9c. Licen:	se number		29d. Date signe	d (Month, I	Dey, Year)
			100	of the	us u			12	200	959		JUNE :	20, 1	999
	10	30 N	ame and address	s of person who	completed cause of	death (Item	23a) (Tun	e Print\			11		2	
		1=7	ISA	J. N.			1 1 7	3 6	2808	HIDDE	EN Hus	LANE	- Pa	TOLLACI
	State	31. De	ete filed (Month	, Day, Year)		rar's Signet	ure a	-			1/			208
	State Registra		JUN	21 199		mer	B.	do	aks	/				2085



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State of Maryland / Department of Health and Mental Hygiene 99 21621

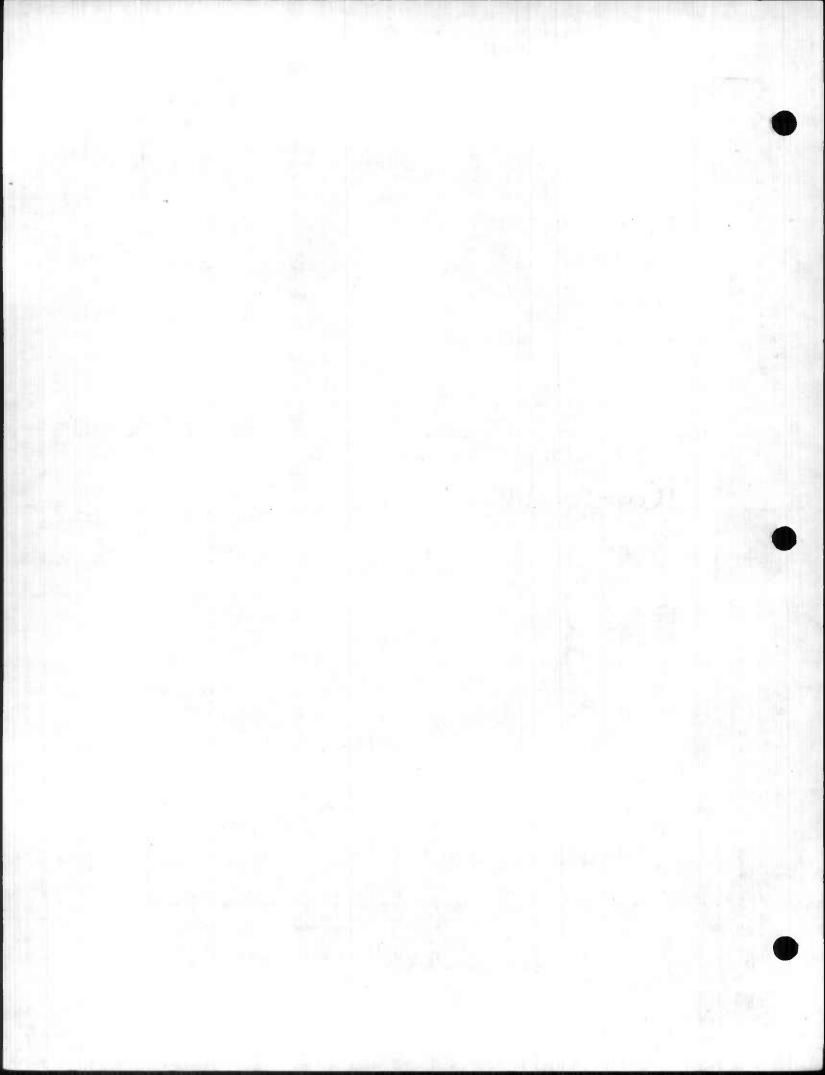
			Cer	tificate of	Death		Reg. No.					
Dhysisian	1. Decedent's Name (First, Middle, La					2. Date of D Month	eath Day	Year	3. Time of Death			
Physician /Medical	Dorothy F	R. Ste	ffens			June 1	7, 1999		7:30 PM			
Examiner	4a Facility Name (If not institution, given 1316 Fenwick Lan	,				n, or Location of Dea Spring	Montgo					
Funeral Director	5. Social Security Number 6. S 075-12-2991	Sex 7. Age (In yrs. 78	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Dete of Bi (Month, D May 5,	rth ay, Year) 1921	9. Birthpi Count New	lace (State or Foreign try) York			
D	Usual Rasidence of Decedent 10a. State 10b. County	10c. Cit	y. Town or Lo	cation				10	0d. Inside City Limits			
he Maryl Mari sho offfied a	Maryland Montgom	ery Sil	ver Sp						1□ Yes 2√ No			
Mile of the Direction o	10e. Street and Number 1316 Fenwick Lane	. #1008		10f. Zip Code 20910			10g. Citizen of V					
fler death with the Mi r lterns 23e or 28e-f siner must be notifie Funeral Directo	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	,S. 13. V		lispanic Origin	n? (Specify Yes or N Puerto Rican, etc.)		e - Amarica	an Indian,			
Exam by	1 Never Merried 2 Married 3 Widowed 4 Divorced	1 ☐ Yas 2 🕅 No If Yes, Give Year or Detas:		I □ Yes 2 No	Specify:	0.000	Specify					
led within 72 hours tygiens. her than "natural", c it, the Medical Exa Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	lent's Usuel Occup kind of work done DO NOT use retire	during most o d)	of working	16b. Kind of Bu					
Har th	17. Father's Neme (First, Middle, Last,	5+	Polit	ical Eco		s Name (First, Middle			rganization			
Martial Hy Martial Hy erked other artic event	Saul Cantor				Pear1	Reiter						
and 2 sh aith and 27 is m or traum	19a. Informent's Name/Relationship (Jerome Steffens	Type, Print) (husband)				or Aural Route Number 1008, Si						
Pages 1 a sent of He ret: if Nem ry or othe	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐		Place of Dispos emetery, cren	sition (Name of natory or other ple	ce)	Date	20c. Location -	City or To	wn, Stete			
the the state of t	4 □ Donation 5 □ Other (Specif	v) Ch		ke Crema		6-18-99		11e,	Maryland			
Depa Depa Impo any le adda	21. Signature of Funeral Service Licer	100~1				rvices, P.		Mary1	and 20910			
	23a. Part1. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Intervel Betwee Onset and Do.											
Physician /Medical	Immediate Cause (Finel	Sanci	C						Onser and Death			
Examiner	disease or condition resulting in death)	a. OCHO	C at a consean	mence of).			_	i 1	IWK			
D # L	b. Corticolasal garationic Degeneration 5											
be executed siclan and bunal-transit	Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (o	or as a conseq	uence of):	17	1	1					
icate be e physician is the burie edical E	that initiated events	c /Vormax	r as a consequ	SSUM	, Hy	arocepho	rlus		4413			
ding physicia se es the bur	resulting in death) Last	d	i as a consequ	uence ory.		•			7			
at the deeth of by the attended for un	Part II. Other significant conditions of	ontributing to don't but not rec	ulting in the ur	adorthing course of	on in Bort I	22h Die	I tobacco usa co	ntribute to	the cause of death?			
by the	Pert II. Other algnificant conditions o	Outributing to death but not resi	outhing our title on	idenying cause gr	ren in Penti.		Yee 250		bebly 4 Unknown			
requires that seen signed to hould be det												
				<u> </u>			s an autopsy ormed?	ava	ere autopsy findings allable prior to mpletion of cause deeth?			
The law ate has page 2						10	Yes 2	10	Yes 200			
ysicien: The is certificate director, pag	25. Was case referred to medical examiner?	Magnitali		low		of Deeth (Check only	one)		7			
t sign	1 Yes 2No	Hospital: 1 Inpatient 2 Inpati	ER/Outpatien 28b. Time of	1 3LI DUA		-	how injury occur		v)			
v Attending Phy ter death. Irector: Atter this n by the funeral of rtification: T	Natural 5 Pending investigation	(Month, Day Year)	Injury	Wo	rk? Yes 2 □ No		the angety edec					
is or Attending P is after death. In Director: After the funerial in by the funerial Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, atri	eet, fectory, office			(Street and Numbown, State)	ber or Rura	l Route Number,			
To the Hospital or Attendition within 24 hours after death. To the Funeral Director: A completely filled in by the funeral Director Medical Certificati	(Check only 2 Medical Exam	yelclan: To the best of my kno- niner: On the basis of examine										
within 2 To the comple	29b. Signatury and title of certifier	and manner states.	Α.	29c. Licens	se number		29d. Dete signe	d (Month, i	Day, Year)			
	* Maria (Lumblin	ms	am	D442	321	6/18	190	7			
20	30. Neme end address of person/who				- 1 10	30	4/10	1				
State	Tanya Lumpkins, M. 31. Date filed (Month, Day, Year)	I.D., 8700 Geor		enue, #4	00, Si	lver Spri	ng, Mary	land	20910			
Registrar	JUN 2 1 1999		B.	dont	<i>y</i> *							



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State of Maryland / Department of Health and Mental Hygiene

				,	Certificate	of Death	Re	ig. No.	21	622
		1. Decedent's Neme (First, Middle, La	ist)				2. Date of Deat	h		. Time of Death
	Physician	Victor Herbe	rt	Stewa	ırd		June 21	Day 1999	Year	4:40 AM
	/Medical Examiner	4a Facility Name (If not institution, give	ve street end number)			4b. City, Town, or	Location of Death	4c. County		
		Carematrix of Si	ilver Spri	nα		Silver S	pring	Montgo	omerv	
_	Funeral			e (In yrs. last bir	thday) If Under 1 Y	ear If Under 24 Hrs		1		(Stete or Foreign
	Director	218-38-9118 Usual Residence of Decedent	1∭ M 2□ F	82	Yrs. Months D	ays Hours Min	Month, Day, Oct. 30	, 1916	United	Kingdom
	Bu Bu	10a. State 10b. County		10c. City, Tow	n or Location				10d.	Inside City Limits
	Man de la la la la la la la la la la la la la	Maryland Montgom	erv	Pool	esville					1∑ Yas 2 No
	or 28a-f. se notified	10e. Street and Number			10f. Zip Co	de	10	Og. Citizen of W	/hat Country?	
		17217 General Cus	ter Way		2083	37		United	Kingd	OM
	her death viner 234 siner must Funeral	11. Marital Status	12. Wes Decedent			of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No-	14. Race	- American I	
Maryland 21215-0020	by F	1 ☐ Never Merried 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 1! If Yes, Give Year or Dates:		If Yes, specify 1 ☐ Yes 2 🖸		rto Rican, etc.)	Specify.	k, White, etc. White	2
5-0	ed within 72 ho ygiens. wer then "neturn it, the Medical.] Completed	15. Decedent's E (Specify only highest gra	ducation	16a.	Decedent's Usual O	ccupation lone during most of wo	orkina	16b. Kind of Bu	siness/Indust	ry
21	U	Elementery/Secondary (0-12)	College (1-4or 5	5+)	life. DO NOT use r	etired)	, and a	Emb a		
2	Post at	12			Accountar	nt	•	Emba	ssy	
Pu	Be Be	17. Father's Name (First, Middle, Last	")			18. Mother's Na	me (First, Middle, A	laiden Sumam	9)	
yla	Ment Ment To To	Herbert Steward				Harrie	tt Elizab	eth Jud	d	
2	d b	19a. Informant's Neme/Relationship (Type, Prift Daugh	ter) 196	. Mailing Address (S	treet and Number or R	lural Route Number,	City or Town,	State, Zip Cod	de)
	and and and and and and and and and and	Victoria Elizabe	th Markus		109 Silve	Crest Dr	ive, Gait	hersbur	g, Maryl	and 20882
ore	- 五百号	20a. Method ol Disposition		20b. Place of cemeter	Disposition (Name or, crematory or other	of r place)	Dete 2	20c. Location -	City or Town,	State
Ĕ	Page mant or ry or	1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif	JRemoval from State		eake Crem		6-21-99 B	eltsvil	le. Ma	rvland
altimore,	A India	21. Signature of Funeral Servica Licer			22. Name and A	ddress of Facility			,	
ğ	Dec	1 Carola	Jan)		neral Serv t Avenue,			Maryla	nd 20910
		23e. Pert1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	the death. Do	not enter the mode o	dying, such as cardia	c or respiratory arre	est,	Inte	proximate erval Between
	Physician	The second secon							On	iset and Deeth
	/Medical	immediate Cause (Final disease or condition	Renal F	ailure						
	Examiner	resulting in death)	6.	Due to (or as e	consequence of):					
			Hyperte	nsion						
	ifficate be executed graphysician and as the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	D	Due to (or as a	consequence of):		-			
68760,	be e ician buris	Cause (Disease or Injury	c						i	
387	icate be physicies the bu	that initiated events resulting in death) Last		Due to (or as a o	consequence of):					
	E 00 E		d						t	
Box	attending to use								1	
o	law requires that the death cer as been signed by the attendir a 2 should be deteched for use npleted by Physician/A	Part II. Other eignificant conditions of	contributing to death be	ut not resulting in	the underlying caus	e given in Part I.				cause of death?
P.0	d by Jetac	Enterocolis with	Clostridi	um Diff	icile.		1 U Y	8 2□ No	3 Probabl	ly 4 🖄 Unknown
Records,	signe be								0.45 144	
0	The law require sate has been signed a should I completed	Multi-Infarct De	mentia, Pa	rkinson	ism, Coror	ary Artery	24a. Was ei	n autopsy ned?	availat	eutopsy lindings ble prior to etion of cause
ec	law as b 2 sl								of dea	th?
E	0 - 5 -	Disease, Recurre	nt Aspirat	ion			1 □ Ye	s 2 No	1 🗆 Ye	es 2 No
	certificate rector, pag	25. Was case referred to medical				26. Place of De	eath (Check only on	θ)		
>	hysici li direc	examiner?	Hospital:	nt 2 ER/Ou	tpatient 3 DOA	Other: 4X Nursing	Home 5 ☐ Reside	nca 6 Othe	or (Specify)	
0	Attending Physician: ordeath. ector: After this certific by the funeral director, iffication: To Be (27. Manner of Death	28a. Dete of Inju (Month, De	ry 28b.	rime of 28c.	Injury at Work?	28d. Describe ho			
0	ath.	1 Netural 5 Pending 2 Accident investigation		, ,,	M	1 Yes 2 No				
Division	tal or Attending P rs after death. al Director: After t ied in by the funers Certification:	3 Suicide 6 Could not b		ury - At home, fa	rm, streel, factory, of	fice	28f. Location (St. City or Town		er or Rural Ro	oute Number,
Ö	o de de de de de de de de de de de de de	4 D TO TION	bulloning, etc	s. (Specify)			Ony or rown	, 51616/		
	hours hours y fille		nyelclan: To the best of							
	To the Hospital or Attending Physician 24 hours state death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	(Check only 2 Medical Examone)	niner: On the basis of and manner ste		d/or investigation, in	my opinion, deeth occ	surred at the time, de	ete and place, a	and due to the	cause(s)
	Meritain Meritain	29b. Signeture end title of certifier	. 0 0	10 - 4 -	29c. Li	cense number	25	9d. Date signed	(Month, Day	Year)
		IN/ON/AMM	ned 1	1 Jan	Man	024593		June 21	1999	
	6	30 Name and address of passes :: 1	completed serves of d	eath /Hom 00-1		JE 1033		ounc 21	, 1000	
		30. Nama and address of parson who				4206	Hyattoui	llo MD	2078	2
	Chah	Mohammed A. Mann 31. Date lited (Month, Day, Year)		ar's Signeture		π200,	nyaccsvi	ile, MD	20/0	_
	State Registrar	JUN 2 2 199		al a Signature	G. Spar	61				



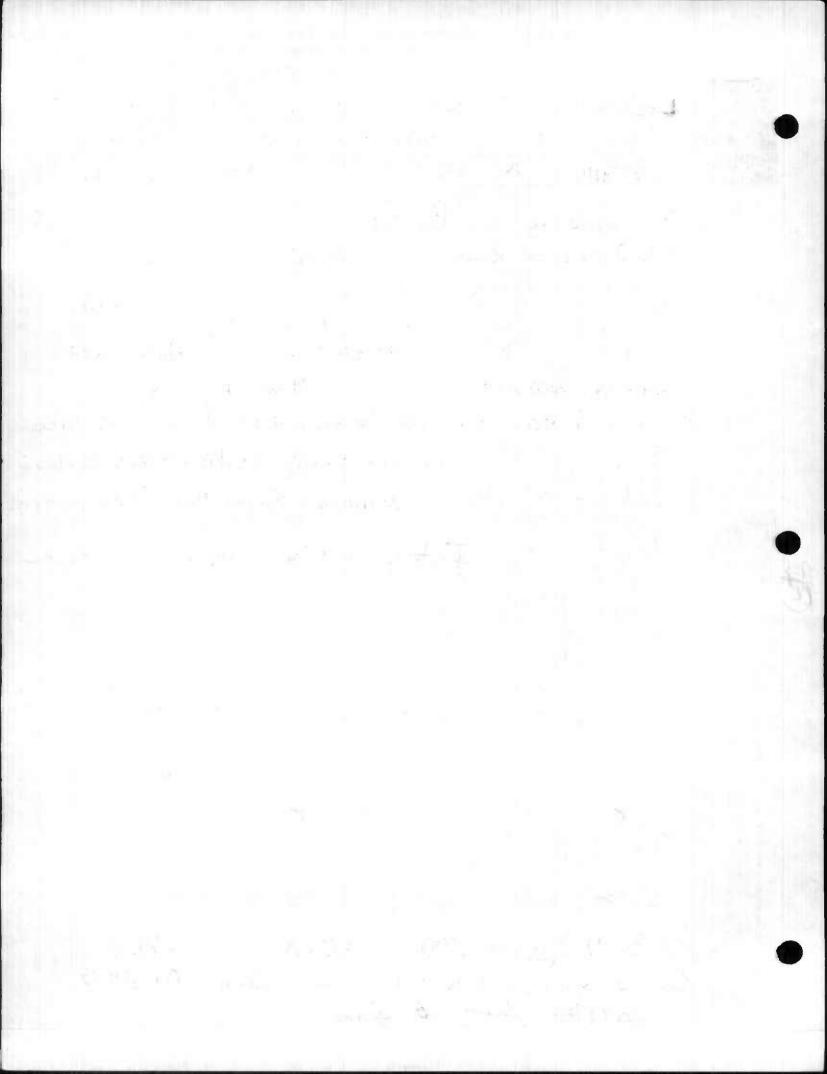
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			State of Ivialylan		ficate of			eg. No.	9 21623
Physic /Med Exami	cai	1. Decedent's Neme (First, Middle, Least 1997) 4a. Facility Neme (If not institution, girls)	1. STREET	Ī		REET	2. Dete of Deet Month JUNE Location of Deeth	Day	Yeer 1 9 9 9 8 : 4 0 P N of Death
LAUIII	1101	SHORE NURSI	NG & REHABIL	ITATION	V CTR	DENT	O N	CAR	DLINE
Funeral Director			Sex 7. Age (In yrs. I		f Under 1 Year Ionths Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey,		9. Birthplace (State or Foreign Country)
OUCO hours efter deeth with the Maryland ural; or Herra 23s or 28s-f show at Everyener must be notified at	ctor	10a. Stete 10b. County MD CAROLI		Town or Locati					10d. Inside City Limits 1 ☐ Yes 2 No
or 28	Director	10e. Street and Number	0		10f. Zip Code		1	0g. Citizen of V	Whet Country?
23a		4386 BETHLEH	IEM KOAD		210	055		US	A
Pr de	Funeral	11. Meritel Status	12. Wes Decedent Ever in U, Armed Forces?	S. 13. Was	Decedent of H	ispenic Origin? (S en, Mexicen, Puert	pecify Yes or No- o Rican, etc.)		a - American Indien, ck, White, etc.
A I A I 3-0020 d within 72 hours eft jiene. r then "neturel", or i	by	1 Never Merried 2 Merried 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Detes:		Yes 2 No	Specify:		Specify	WHILE
within 72 ho ene. than "neturn he Medical.	lete	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give kind	t's Usuel Occup d of work done	etion du <i>ring</i> most of wor d)	king	16b. Kind of Bu	usiness/Industry
z i z withii	Completed	Elementery/Secondery (0-12)	College (1-4or 5+)	1 7	MEMA			Home	MAKER
7. 6 2 8	BeC	17. Fether's Neme (First, Middle, Last)		10 (12.11	-	ne (First, Middle, A		
- 4 9 p 6	ToB	JOHN W. B	RADIEY			MARY	' L. V	OLK	
A DE E		19e. Informant's Name/Reletionship		19b. Meiling A	ddress (Street	end Number or Ru	rel Route Number		Stefe, Zip Code)
C = 0 F		JOSEPH H.S	treet -Son	4386	BETHL	EHEM	59. Hr	eston	MD 21655
2 0 4 2 0		20a. Method of Disposition Burial 2 Cremetion 3 C Onetion 5 Other (Specie	Removel from State	ace of Disposition emetery, cremeto	on (Neme of ory or other plea	sta 1	chalm.	D	City or Town, Stete W, MD 21655
Dallimo permit. Page Depertment of Important: If any Injury or once.		21. Signetyp of Funeral Service Lice	. 91	22. No	eme and Addre		611919	11621	w, MD 21655
E Bade Silve	23a. Pert1. Enter the disease, or com shock, or heart fellure. List only	plications that caused the deeth one ceuse on each line.	. Do not enter the	LL) AMS		or respiratory arre	Me, fr	Approximate Interval Between Onset and Death	
/Medical Examiner	er	Immediate Causa (Final disease or condition resulting in death)	a. Due to (or	as a consequen		hemo	whose		2uh
oof ou, tificate be executed g physicien end es the buriel-transit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	b. — Due to (or	es a consequen	ica of):				
be e burie		cause. Enter Underlying Cause (Disease or injury that initieted events	c						
	/Medical	resulting in death) Lest	Due to (or	es e consequen	ca of):				
death cert	clar	Death Other I office a second							
d by th	y Physician/N	Pert II. Other significant conditions of	ontributing to death but not resu	iting in the under	rlying cause giv	en in Pert I.	23b. Did to	2-4	ntribute to the cause of death? 3 Probably 4 Unknown
aw requires s been sign 2 should be	Completed by						24e. Wes e		24b. Were autopsy findings available prior to completion of cause of death?
The law ate hes bege 2 s	E						1 □ Ye	s 25 No	1 ☐ Yes 2 ☐ No
ician: The certificate rector, peg	Be	25. Wes case referred to medical				26. Place of Dee	th (Check only on	-	
- Z v 0	2	examiner? 1 Yes 25 No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient	3 DOA Oth	er: 4 Nursing H	ome 5 Reside	nca 8 🗆 Oth	er (Specify)
Attending Physician: r death. ctor: After this carific by the funeral director,		27. Menner of Deeth Natural 5 Pending 2 Accident Investigatio	(Month, Dey Year)	28b. Time of Injury	28c. Injur Wor M 1 🗀	y et k? Yes 2 □ No	28d. Describe ho	w Injury occur	red
DIVISION O he Hospital or Attending Ph in 24 hours after deeth. he Funeral Director: After th pletely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined		me, ferm, street,	fectory, office		28f. Location (St. City or Town		er or Rurel Route Number,
UIV the Hospital or / in 24 hours after the Funeral Dire npletely filled in b	edicai C	29a. Certifier (Check only one) Certifying Physics (Check only one)	ysictan: To the best of my know niner: On the bests of exeminati end menner steted.	rledge, deeth oc on end/or invest	curred at the tin igetion, In my o	ne, date and piece pinion, death occu	, end due to the ce rred at the time, de	euse(s) end ma ete end plece,	nner as steted. end due to the cause(s)

pompleted cause of death (Item 23e) (Type, Print)

32. Registrer's Signeture

6. Land 29d. Dete signed (Month, Dey, Year) To t 31. Dete filed (Month, Dey, State JUN 2 1 1999 Registrar DHMH 16 Rav 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month 0715 THOASRUO VER ARNE 1999 10 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) 7620 OLD GEORGETOWN ROAD BETHEZON MOWTGONFRY If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 12 M 2□ F Months Deys Hours 444-66-0331 Yrs. 38 July 6, 1960 Switzerland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Bethesda 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7620 Old Georgetown Road, #308 20814 Norway 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ☼ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 5+ Certified Public Accountant | Accounting Firm 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Agmund Thorsrud Aud Lindberg 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Bjorn Thorsrud/ Brother 110 Friar Lane, Lima, Ohio 45805 20b. Place of Disposition (Name of cemetery, cremetory or other place) June 23, 1999 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from State 4 ☐ Donetlon 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue MO0689 Bethesda, Maryland 20814-3501 lisease, or complications that caused the child. Do not enter the mode of dying, such as cardiac or respiratory errest, liture. List only one cause on each line. Intervel Between Onset end Death Immediate Ceuse (Finel disease or condition resulting in deeth) GUNSHOT WOUND TO Due to (or es e consequence of): Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobscco use contributs to the causs of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evaileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? 20 NO 1 Yes 2 No 26. Plece of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Injury et 28d. Describe how injury occurred Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury et Work? 28e. Dete of Injury (Month, Dev Year) Injun 1 Neturel

physician and s tha buriai-transit requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 88 use has

Physician

/Medical

Examiner

Examiner Physician/Medical þ Completed paga 2 s cartificate Hospital or Attending Physician:
24 hours after death.
 Funeral Director: After this cartifica Be Certification: To funaral

filled in

To the Hosp within 24 ho To the Fune completely f

50

Medical

Physician

· /Medical

Examiner

Funeral

Director

r 28a-f show

7 is marked other than "natural", or items 23s or traumstic event, the Madical Examiner nault be 1

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mantal Hygiane. I important: If item 21's marked other than "natural", or ther eny Injury or other traumatic event.

Baltimore, Maryland 21215-0020

Directo

Funeral

p

Completed

Be

with the Maryland

death

25. Wes case referred to medical exeminer?

1 No 2 No 27. Menner of Deeth

2 Accident

4 Homlcide

3 Sulcide

29a. Certifier

5 Pending Investigation 6 Could not be determined

PPP1,81 2006 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

HOME

0715

2 140 1 ☐ Yes

SINGUE GOUSTOT LOUND - HEAD

28f. Location (Street end Number or Rural Route Number, City or Town, State) 7620 OLO CEBREFOUND RO, PETTESON

(Check only 29b. Sign

dedical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

18,1999 015236

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARC MARGOUS, M.O. (OME) 11125 HOCKUIUT PIKE, POCKUIUT, MO 2085 2

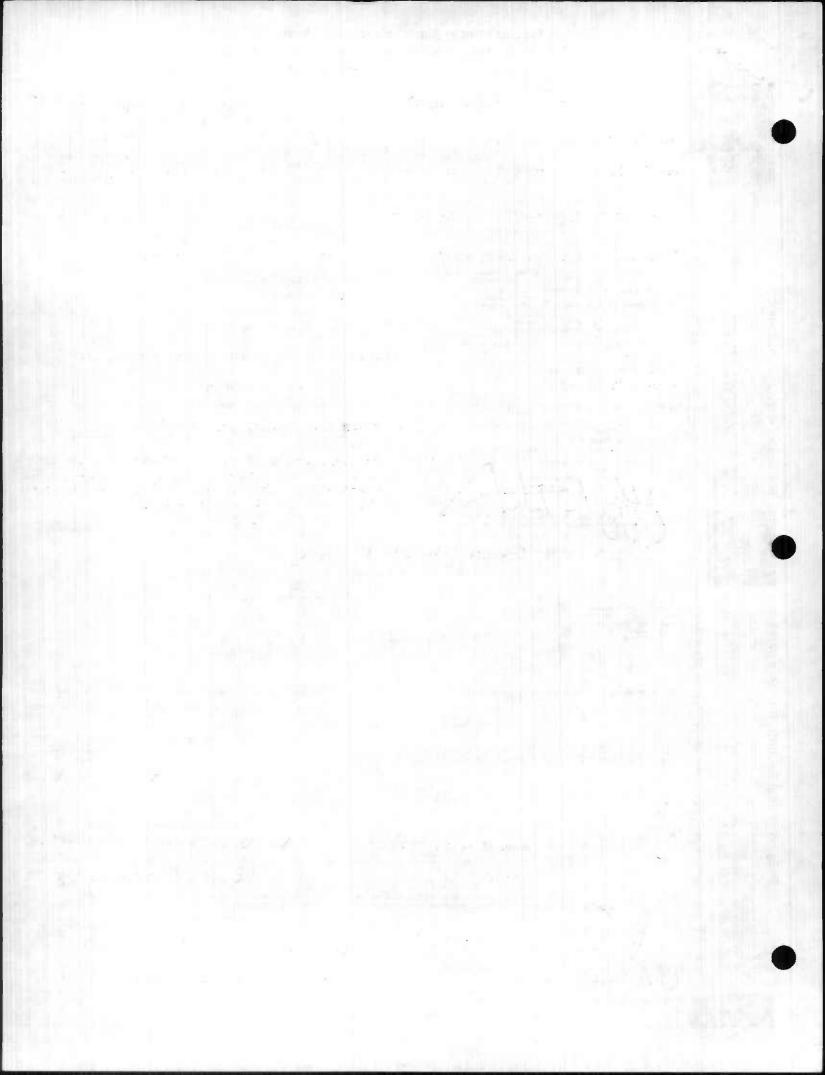
Registrar

31. Dete filed (Month, Dey, Year)

1999 JUN 25

32. Registrer's Signature reper

1 Certifying Physician: To the best of my knowledge, deeth occurred et lhe time, dete end piece, and due to the cause(s) and menner as stated



		Certificate of Death									Reg. No.				
Physicia /Medica		1. Decedent's Name (First, Middle, Last) Tohnny			Thomas		S ,	Jr.			2. Dete of Deeth Month D		1999	3. Time of Death 12:25 PI	
Examine		4a Fecility Neme (If not institut Laurel		gional	Hos	pital				un, or Location	el	Pri		George'	
Funeral Director		5. Social Security Number 258-74-5681 Usual Residence of Decedant			7. Age (In yrs. last birthday) H Under 1 Year if Under 1 Year Months Deys Hours			Hours	Min. (
a di H	tor	10e. Stete 10b. County Florida Dade				10c. City, Town or Location Miami								1 ☐ Yes 2 ☐ No	
	al Direc	10e. Street and Number 1790 N.W. 114st.				10f. Zip Code 33167				10g. Citizen of What of United State			•		
	Completed by Funeral Director	11. Meritel Stetus 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Wes Deceder Armed Forces 1 □ Yes 2 ☑ If Yes, Give Yeer or Detes					Vas Decedent of Hispanic Origln? (Spec Yes, specify Cuben, Mexicen, Puerto F			gln? (Specify , Puerto Rice				- American Indian, k, White, etc. Black	
	ompleted	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or				16e. Decedent's Usual Occupetion (Give kind of work done during most of wo life. DO NOT use refired) Truck Driver			of working	16b. Kind of Business/Industry Private			dustry		
	To Be C	17. Fether's Neme (First, Middle, Last) Johnny Thomas, Sr.				1					eme (First, Middle, Melden Sumeme) 1ia Baker				
Health end Name 27 is ma		19e. Informent's Neme/Reletio		1790 h	1.W.	114S	treet		oute Number, Flor		n, Stete, Zip	Code)			
nent o		20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☒ Removei from State 4 ☐ Donetion 5 ☐ Other (Specify)				20b. Plece of Disposition (Neme of cametery, cremetory or other plece) Southern Memorial Park 6/26/99 Miami, Florid									
Department of Important: if eny injury or page.		21. Signalur of Funeral Service Licenses 22. Name end Address of Fecility Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747													
hysician /Medical Examiner		23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) e. SUDDEN DEATH										Approximate fnterval Between Onset end Deeth			
tificate be ig physicia as the bur	Medical Examiner	Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of):													
	/ Physician/M	Pert II. Other significant conditions contributing to death HYPERTENS									23b. Did tobacco use contribute to the cause of death 1 □ Yas 2 ☑ No 3 □ Probably 4 □ Unknown				
2 5 2	Completed by										24e. Wes er perform	ned? eveileble prior to		veileble prior to empletion of cause	
certificate hes rector, page 2:	Be Com	25. Wes cese referred to media		26. Place of Deeth								Yes 2 No			
s certific director,	10 8	examiner? 1 ☐ Yes 2 ☑ No	Hospital: /								her (Speci	(v)			
E E =		27. Menner of Deeth 1 ☑Neturel 5 ☐ Pend	ding stigetion	28e. Date of		28b. Time o Injury		8c. Injur Wor		28d.	28d. Describe how injury occ				
	Certification:	3 Sulcide 6 Coul 4 Homicide dete	d not be mined	28e. Plece of Injury - At home, building, etc. (Specify)			farm, street, fectory, office				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	edicai	29e. Cartifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner es stated. 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete and piece, end due to the ceuse(s) end manner stated.													
To the Tour Comp	Σ	29b. Signeture end title of cartil	ier				290	. Licens	e number		29	d. Dete sign	ed (Month,	Dey, Year)	
(Ac. in	/	M N	Who A	in -		1	17	361		61	181	99	

State

· Registrar

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Arvind M. Mehta, MD 7100 Baltimore Ave., #509 College Park, MD 20740

31. Dete filed (Month, Dey, Year)

JUN 2 2 1999

22. Registrer's Signeture

D. Asach

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death JUNE 18,1999 **Physician** CATHERINE VERONICA TURNER 10:15PM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner 309 MILL SWAMP ROAD **EDGEWATER** ANNE ARUNDEL If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) MAY 28, 1935 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthpiaca (State or Foreign **Funeral** Months Days Hours 1□M 2√2 F WASHINGTON D.C 577-44-2360 Director 64 Usuel Residence of Decedant the Maryland 10a Steta 10b. County 10c. City, Town or Location 10d. insida City Limits ehow ral", or items 23s or 28s-f show Examiner must be notified at 1 ☐ Yes 2√2 No Director **EDGEWATER** MARYLAND ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 309 MILL SWAMP ROAD 21037 UNITED STATES Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indien, Black, White, atc. 12. Was Dacedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2X No If Yas, Giva 11 Maritai Status 1 Nevar Married 2 Merried Baltimore, Maryland 21215-0020 genit. Pages 1 and 2 should be filed within 72 hours afti Department of Health and Montal Hygiene. Important: If them 27 is marked other than "natural; or any Injury or other traumatic event, the Model Event Mode. 1 ☐ Yes 2 ☐XNo Specify: Specify: White p 3 Widowed 4 Divorced Yeer or Detes Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Office Manager Private Industry 18. Mothar's Neme (First, Middle, Meiden Sumeme) 17. Fathar's Name (First, Middle, Last) Be ANGELINA CARARRA Humberto Imbres 19a. Informant's Nama/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEPHEN F. TURNER (SON) 6219 WINSLOW CT., FAIRFAX STATION, VA 22039 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 X Burial 2 Cremetion 3 Removal from State Resurrection Cemetery 6/22/99 Clinton, Maryland 4 Donation □ Othar (Specify) 22. Nama and Addrass of Facility GEORGE P. KALAS FUNERAL HOME, P.A. unarel Sarvice Licen ala 6160 OXON HILL RD. OXON HILL, MD. 20745 Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, or heart failure. List only one ceuse on each line. Approximata Intervel Between Onset and Death **Physician** colonic cavainama /Medical immediete Causa (Final diseasa or condition resulting in death) Examiner Due to (or as a consequence of): Examiner ician and burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laeding to immadiate cause. Entar Underlying Cause (Disease or Injury that initiated events rasulting in daeth) Last Dua to (or as a consequence of): P.O. Box 68760. Physician/Medical Dua to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part t. 1 Yas 2 No 3 Probably 4 Unknown been signed to should be det Records, þ Be Completed 24b. Ware autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 1 □ Yas 2 □ No Division of Vital or Attending Physicien: 25. Was casa rafarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this funeral 27. Mannar of Death 28e. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Affer 1 Naturel 5 Pending death. 1 Yas 2 No investigation 2 Accidant after death Director: 6 Could not be detarmined 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) filled in by 4 Homicida 24 hours a Hospital 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Cartifier Medical **completaly** To the within 2 29d. Deta signed (Month, Day, Year) JUNE 19,1999 900 Bestgate Annapolis, und. 21401 30 Nama and address of person who completed ceuse of deeth (Item 23a) (Type, Print) Selouich, W.O 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State JUN 2 1 1999

DHMH 16 Rev 6/95

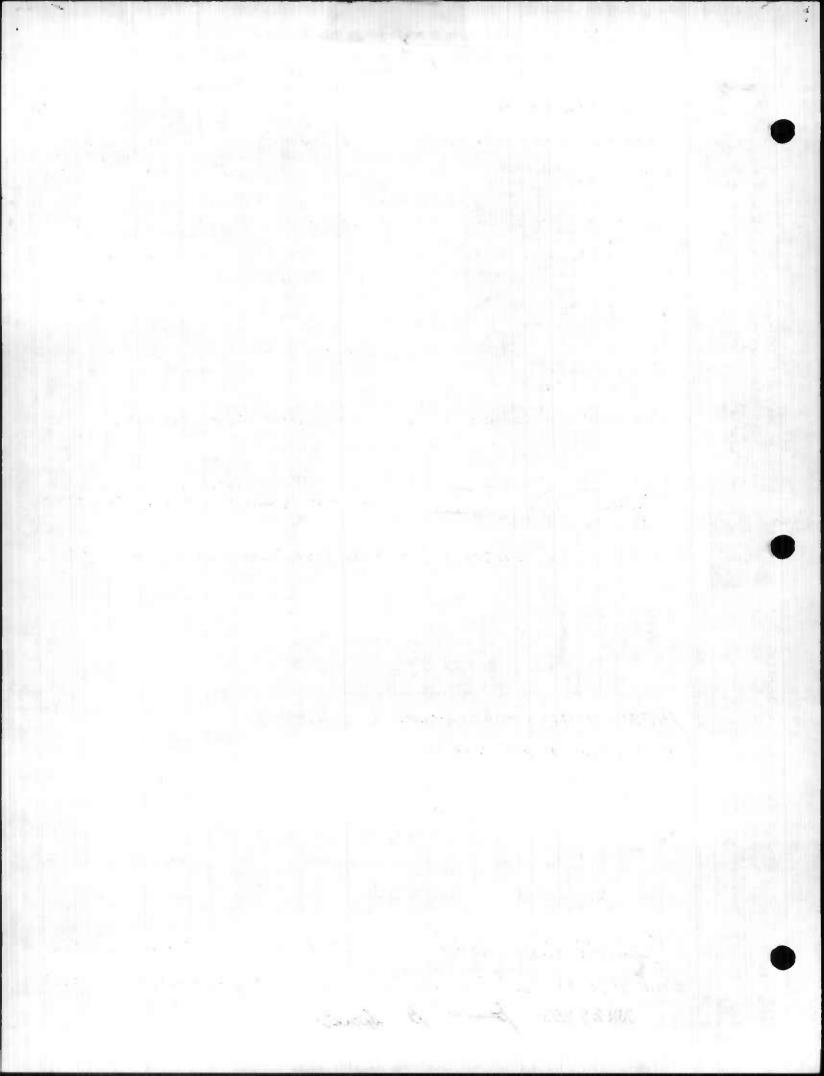
Registrar

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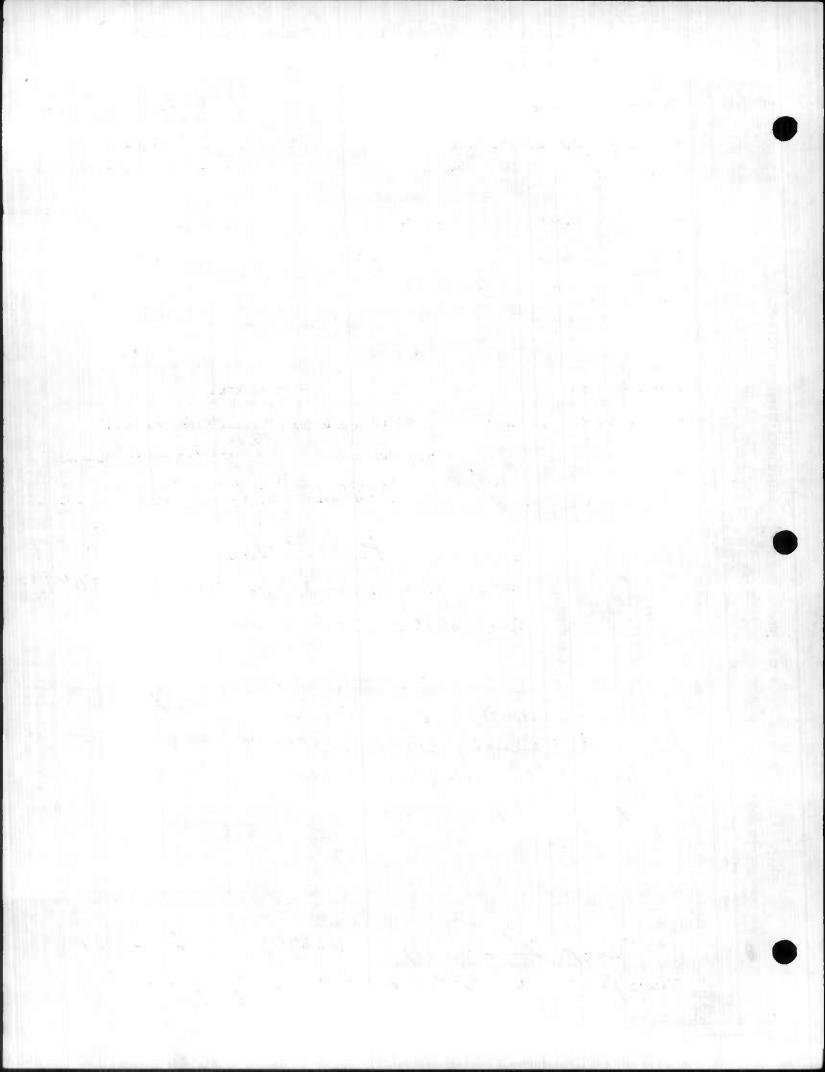
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State of Maryland / Department of Health and Mental Hygiene 99

				Cert	ificate of	Death			Reg. No.						
	1. Decedent's Name (First, Middle, L	est)						2. Dete of De Month	eath Day	Yaar	3. Time of Death				
Physician - /Medical	Bernard Arthu	r Tatum						June		999	2:42PM				
Examiner	4a Facility Neme (If not institution, gi	ve street end number)			4b. City, To	own, or Lo	ocation of Deet	h 4c. Count	y of Death					
	Washington Ad	ventist Ho	spital			Takon	na Pa	rk	Mor	tgom	ery				
Funeral			ga (In yrs. last bir		If Under 1 Yea Months Day		24 Hrs. Min.	8. Date of Bir (Month, De	rth av. Year)	9. Birth	place (Stete or Foreigntry)				
Director	578-09-2826	1₩ 2□F	86	Yrs.	Working Day	110013	101111.	June 2	28, 1912	Was	sh., D.C.				
	Usual Residence of Decedent														
ms 23a or 28a-f show creat be notified at neral Director	10a. State 10b. County District of Colu	umbia	10c. City, Town		won Washing	ton					10d. inside City Limi				
or 28	10e. Street and Number			10f. Zip Code					10g. Citizen of	Whet Cou	ntry?				
23a c	461 H St., 1	N.W. #11	1	20001					United	Sta	tes				
natural, or itams 23a	11. Marital Status	12. Was Decedant Armed Forces		13. W	es Decedent of Yes, specify Cu	Hispanic Or	rigin? (Sp	ecify Yes or No			can indian,				
	1 Navar Married 2 Married	1 ☐ Yes 2 🖎			Yes 2X N			rilouri, oto.,	100	nck, White, etc. fv: Black					
. B	3 Widowed 4 Divorced	If Yes, Give Yaar or Datas:		11	1 162 SEZIA	о зресну			Specia	y: D.	Lack				
ygiene. Nor than "natural", It, the Madical Ex. Completed b	15. Decedent's E (Specify only highast gi	ducation	16a.	Decede	nt's Usuel Occ nd of work don	upation	et of work	ina	16b. Kind of E	lusiness/In	ndustry				
- H -		College (1-4or	5+)	life. DO	NOT use reti	red)		urg							
To The	Elementary/Secondary (0-12)			Cab	& Truc	k Driv	er		Pri	vate					
S S E	17. Father's Name (First, Middle, Las	*				18. Moth			, Maiden Sumai	ne)					
9 9 -	John M. Tati	ım						Nannie	Jones						
- 1	19a. Informent's Name/Relationship Arlene Duckett								D.C. 2		p Code)				
of Haalth if item 27 i	20e. Method of Disposition		20b. Plece of	f Disposi	tion (Neme of	to a ch		Dete	20c. Location	- City or T	own, State				
OF OF	1 Bunal 2 □ Cremation 3				otory or other p	_	1	5/20/00	Landov	0 × M	ra .				
Department of Important: If it any injury or o	4 Donation 5 Other (Spec		пагшог		emorial		ite		-						
mpol any Ir	22. Name and Address of Facility Stewart Funeral Home														
0 2 4 0	10/m 1. 1	(lward			4001 B	enning	Rd.	, N.E.	Wash.,	D.C.	20019				
	23a. Part1 Enter the disease, or cor shoot or heart failure. List only	4001 Benning Rd., N.E. Wash., D.C. 20019 23a. Part1 Enter the disease, or complications that count in death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shoot or heart failure. List only one cause on each line. Approximate Interval Between													
ysician	shoot, or heart failure. List only one cause on each line. Interval Betwee Onset and Deal														
Medical	Immediate Cause (Final disease or condition resulting in death) ———————————————————————————————————														
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ž ž	Sequentially list conditions, If any leading to immediate Due to (or as e consequence of):														
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ate has been signed by the atten page 2 should be detached for u Completed by Physiciar	ANTENIOS CLEROT	- 1	1					24e. Wa	s en eutopsy ormed?	24b. W	Vere autopsy finding vellable prior to				
should should	Valvular H	earl Di	Jegge					pen	Offined r	C	ompletion of ceuse if death?				
page 2								10	Yes 2 No						
certificate rector, pag	05 116										☐ Yes 2☐ No				
is certific director,	25. Was case referred to medicel examiner?	Hospital:	W			Whor:		th (Check only							
E =	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpat		tpatient Time of	3LI DOA	4 LI N	ursing Ho		how injury occu		ify)				
After funer fion	1 Natural 5 ☐ Pending	(Month, Di	ay Year)	njury	28c. In W	ork? □ Yes 2 □	No	ZOG. Describe	Tiow injury occu	1100					
y the f	2 Accident invastigation 3 Suicide 6 Could not	he -					JINO	ON Launtine	(Ctonat on d No.	has as Dou	m / Davita Alumbas				
ilrec in by	4 Homicide determined	259. Piece of in	ijury - At home, fe tc. <i>(Specify)</i>	erm, stree	et, factory, offic	0			wn, State)	Del Ol Hui	rel Route Number,				
E O	17														
To the Funeral Director: Affect completely filled in by the funeral Medical Certification:	(Check only 2 Medical Exa	hysician: To the best miner: On the basis of	of examinetion en	death o	stigation, in my	time, date a	nd place, ath occur	and due to the	ceuse(s) and m	anner as	stated. to the cause(s)				
ed plet	one)	and manner s	tated.												
To to	29b. Signature and titla of cartifier	1			29c. Lice	nse number	7		29d. Date sign						
	Sunlan	Levore	400		00	115.	2 X		JUNE	22,	1999				
	30. Name and address of person who	completed ceuse of	death (Item 23a)	(Туре, Р	rint)		0,1	,	- 111	11.12					
		GRE, MID	42030	Sie	TUSBL	Rex	AL	14917-	5V1/121	W)	20781				
State	31. Date filed (Month, Dey, Year)						-								
Registrar	31. Date filed (Month, Dey, Year) 32. Registrar's Signature														
				. ,	THE RESERVE AND ADDRESS OF THE PERSON NAMED IN										



Months Days Hours Min. Month, Dey, Year) E	8:18pm
Hilary Maud Thomas June 20, 1999 4s Facility Nama (If not institution, give street and number) Washington Adventist Hospital S. Social Security Number 5. Social Security Number 1. Social Security Number 1. Aga (In yrs. last birthday) Months Days Hours Min. (Month, Dey, Year)	8:18pm
4s Facility Nama (If not institution, give streat and number) 4s Facility Nama (If not institution, give streat and number) 4s Facility Nama (If not institution, give streat and number) 4s Facility Nama (If not institution, give streat and number) 4s City, Town, or Location of Death 4c. County of D Takoma Park Montgom 5. Social Security Number 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Months Days Hours Min. Month, Days Hours Min. Month, Days Hours Min. Month, Days Hours Min. Month, Days Hours Min.	
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5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. 8. Dete of Birth Months, Days Hours Min. (Month, Dey, Year) 9.	
Months Days Hours Min. Month, Dey, Year) 5	Birthplace (Stata or Foreign
Usual Rasidanca of Decedant	Jamaica
10a. Stata 10b. County 10c. City, Town or Location	10d. Insida City Limits
Manufacture (C)	1 ☐ Yas 2 ☐ No
Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What	t Country?
Tot. Sheet and Nombel	Country
8711 Bradford Road 20901 Jamaica	
11. Marital Status 12. Was Decedent Evar in U,S. Armed Forcas? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Ricen, atc.) 14. Race - A Black, W	Amarican Indian, White, etc.
3 H Widowed 4 □ Divorced	lack
15. Decedant's Education 16a. Decedent's Usual Occupation 16b. Kind of Busine	ess/Industry
(Specify only highest grada completed) (Giva kind of work dona during most of working lifa. DO NOT use retired)	
15. Decedant's Education (Specify only highest grada completed) Elemantery/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife Own Home	
Thomas Osborne Mable Mitchel	
19a. Informant's Name/Ratationship (Typa, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State	
Beverly Martin / Daughter 3201 Carnegie Hall Circle, Olney, MD 20	832
20e. Mathod of Disposition 20b. Place of Disposition (Nama of cametary, cramatory or other place) 20c. Location - City	y or Town, Stata
1 Reurial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) Dembigh Cemetery 30,1999 Clarendo,	Jamaica
21. Signature of Funara Sarvice Licensaa 22. Nama and Addrass of Facility	
Francis J. Collins Funeral Home, In	nc.
500 University Blvd W., Silver Spr.	ing, MD, 2090
23a. Pert 1. Enter tha disease, or complications that ceused tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one dause on each line.	Approximete Intervel Between
	Onsat and Death
Immediate Ceuse (Finel disaasa or condition Congletic Congletic)	10 day
rasulting in death) a. Due to (or as a consequence of):	
	10 day
Sequentially list conditions, if any, leading to Immedies course Enter linderly lind	10
Sequantially list conditions, if any, laading to Immadieta Dua to (or as e consequence of):	
Sequantially list conditions, if any, laading to Immadieta ceuse. Enter Underlying Ceuse (Disaasa or injury Ceuse (Disaas	
Ceuse (Disaasa or injury that initiated avants resulting in deeth) Last Due to (or es a consequence of):	
ž i	
d	
Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceusa given in Pert I. 23b. Did tobacco use contributing to death but not resulting in the underlying ceusa given in Pert I.	bute to the cause of deat
1 Yes 20 No 30	☐ Probably 4 ☐ Unkno
Chronic Obstructive line Disesse	
Chyonic Dostructive Line USES	24b. Ware autopsy findings
Chronic of thereding with Chronic Anemia performed?	availabla prior to complation of ceusa
Gastresophered hoffer diseare 10 yes 2000	of death?
Jashresophegen hoffer aseary 10 yes 2000	1 ☐ Yas 2 ☐ No
25. Wes casa raterred to medical 26. Place of Death (Check only one)	
Hospital: Winnetient 3 FR/Outgetient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other /	(Specify)
27. Manner of Deeth Neturel 5 Pending investigation 3 Suicida 4 Homicide 4 Homicide 28e. Placa of Injury - At homa, farm, streat, factory, office 28f. Location (Streat and Number of City or Town, State) 28f. Location (Streat and Number of City or Town) 28f. Location (Streat and Number of City or Town) 28f.	
3 Suicida 6 Could not be 28e. Placa of Injury - At homa, farm, streat, factory, office 28f. Location (Streat and Number of determined)	or Rural Routa Number
4 Homicide determined building, etc. (Specify)	or rearest reaction reaction,
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and dua to the causa(s) and manna one of axaminetion and/or invastigetion, in my opinion, daath occurred at the time, dete end plece, and and mannar stated.	ar as stated. I due to the cause(s)
one) and mannar stated.	
	vionth, Dey, Year)
	1-99
29b. Signatura and titla of certifiar 29c. Licensa number 29d. Data signed (No. 1) 26767 29d. Data signed (No. 1) 26767	1-99
29b. Signatura and titla of certifiar 29c. Licensa number 29d. Data signed (N 29d. Data si	20801
29b. Signatura and titla of certifiar 29c. Licensa number 29d. Data signed (No. 1) 267°7 6-2/	2090/

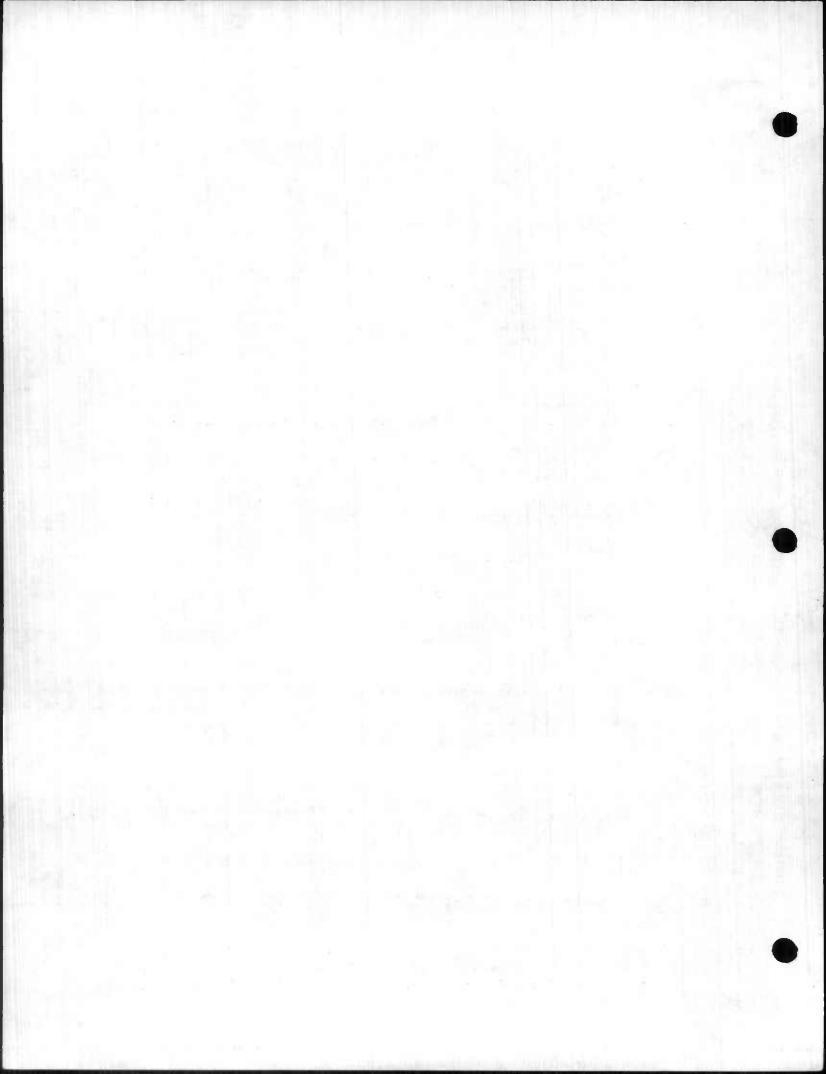


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State of Maryland / Department of Health and Mental Hygiene QQ 21600

					Cei	tificate of	Death		Re	g. No.) (-100	29
D 4 -1-1		1. Decedent's Name (First, Middle, Li	ıst)						ate of Deat	Day	Yeer	3. Time of	Death
Physici /Medic		Helen	Tinkel	man					ne 20		1 001	10:4	5 AM
Examin		4a Facility Name (If not institution, gi	ve street and number)				4b. City, Tox	wn, or Locatio	n of Death	4c. County	of Deeth		
81		Holy Cross Hospit	al				Silver	Sprin	g	Montgo	mery		
Funeral				e (In yrs. le	ast birthday)	If Under 1 Yea Months Days	r If Under 2		ate of Birth Month, Dey,	Year)	9. Birthpl Count	lace (State o	r Foreign
Director		073-01-8210	1□M 2∑F	82	Yrs.	Inolana Bay	71.00.10	Au	gust	15, 191	.6 No	ew Yor	:k
9		Usual Residence of Decedent		10- 00-	Town sets							ad badda Ol	ta . 6 1 - ta -
the Marylar 28s-f show potified at		10a. State 10b. County		TUC. City	, Town or Lo	Cation					10	0d. Inaide Ci 1XXYes	*
M Page	cto	New York Dutchess		Poug	ghkeep								2010
fi 8 e	Directo	10e. Street and Number				10f. Zip Code			10	g. Citizen of V	Vhat Coun	try?	
after death wi or Nerra 23a arricher mant b	8	6 Lafko Drive				1260	5			nited S		_	201
r de	Funeral	11. Merital Status	12. Was Decedent Armed Forces?		S. 13. \	Nas Decedent of f Yes, apecify Cui	Hispanic Orig ban, Mexican	gin? (Specify ' , Puerto Ricar	Yes or No- n, etc.)		e - America k, White, e		
8 8 8		1 Never Merried 2 Married	1 Yes 2	No		Yes 2000	Specify:			Specify	. Whit	te	
d within 72 hours after giene. If then "natural", or file the Medical Examine	d by	3€XWidowed 4 □ Divorced	Year or Dates:										
72 Tage	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced (Give	lent's Usual Occu kind of work done DO NOT use retin	ipation e during most	of working		16b. Kind of Bu	isiness/Ind	lustry	
then.	d H	Elementary/Secondary (0-12)	College (1-4or 5	5+)			90)			0 11			
A Paris	8	12	**		Hom	emaker	40.14-11-	de 81a 1871-		Own Hom			
8105	Be	17. Father'a Name (First, Middle, Last Frank Weiss	/					Newman		faiden Sumem	6/		
Men	2												
d 2 shou th and M 7 is mark traumati		19a. Informant's Name/Reletionship	**			ng Address (Stree							
			ghter	DOM: EN		rizon Hi	II Dri	<u> </u>					
it. Pages 1 authorities 1 auth		20a. Method of Disposition XIX Burial 2 ☐ Cremation 3 ☐	Removel from State	CB	metery, cren	sition (Name of natory or other pl		Tune	22	20c. Location -			
artmen ortant: Injury		4 Donation 5 Other (Speci		Bet	h El	Cemetery		1	999	Poughke	epsi	2, NY	
mit pour		21. Signature of Funeral Service Lice	1990 #M006	90	22 S.0	Name and Addi	ress of Facility	eral H	OME				
88198		Soured	1 Cause	n	73					Pougke	epsie	NY	1260
E KILL		23a. Pert1. Enter the disease, or con shock, or heart failure. List only	plications that caused	the death	. Do not ent							Approximate Interval Bet	0
Physician		SHOOK, OF HEAR FAILURE. LIST OFFI	One cause on each in	no.								Onset and I	
/Medical		Immediate Cause (Final disease or condition	Condio	n1ma		A					1	E W4	. 4. 0. 0
Examiner		resulting in death)	a. Cardio		as a conseq							5 Minu	tes
	je		Intra-								31.5	8 Hour	. 6
executed in and ial-transit	Examiner	Sequentially list conditions	b		as a conseq						110	Hour	5
an an an an an an an an an an an an an a	Ä	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		Contract of	Water Control								
death certificate be executed e attending physician and of for use as the burial-transit	Medicai	that intieted events	C	Due to (or	as a conseq	uence of):							
g ph	8	resulting in death) Last		,							i		
attendin for use	3		d								<u> </u>		
death d for	Physician	Pert II. Other significant conditions	contributing to death b	ut not resul	lting in the w	nderlving cause g	iven in Pert I	1	23b. Did to	bacco uae cor	ntribute to	the cause	of death?
at the de datached	hys	Total agament conditions	with boling to death o	0111011030	KRIG III IIIO DI	roonyang cause g	processing of the			a 2X No			
that the debt	by P									220110	40,,,,,	,	
law requires that the de as been signed by the 2 should be detached									24a. Was a	n autopsy	24b. We	ere autopsy t	findings
shoe shoe	ete								perform	10d?	cor	aileble prior t mpletion of d death?	ause
he lav	Completed								400	0170 11			l ava
n: The icate h		ar was selected as a selected as	1							s 2 No	11	Yes 2	NO
Physician: The law this certificate has trail director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:			_ 0	ther	of Deeth (Ch					
al al	2	1 ☐ Yes 2\(\)\(\)\(\)\(\)\(\)\(\)\(\)\(\)\(\)	1 LX Inpatie		R/Outpatien 28b. Time of	I SLI DON	4 🗆 140			nce 6 Oth		/)	
- p 2 2	lo	1 Neturel 5 Pending	28a. Date of Inju (Month, Da	y Year)	Injury	W	ork? ☐Yes 2☐!		Describe 110	w injury occur	00		
6455	cat	2 Accident investigation 3 Suicide 6 Could not be							continu /Ct	reet and Numb	or or Pur	I Douto Ahm	har
or Attending after death. Director: Afte d in by the fund	Certification:	4 Homicide determined	building, et	ury - At hor c. (Specify)	me, tarm, str)	eet, factory, office	9		City or Town		er or nure	I HODIE NUIT	Der,
Hospital or 124 hours after Funeral Direction of the property filled in the property of the property filled in the property fill	3										7000		
Hosp Fune Tely f	edicai	(Check only 2 Medical Exam	nysician: To the best of miner: On the basis of	examinati									s)
To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	Med	one)	and manner str	BIOCI.		20a 1 i	nse number		24	9d. Date signe	d (Month	Day Year	
5 × 5 %	-	29b. Signature and title of certifier	A			29C. LICON	190mun per	1.	-	v . Date signer	a (month), i	100	9
10		Junellon	MD			ע	12/1/	4	J	une 2	.0,	177	1
		30. Name and address of person who	completed cause of d	leath (Item	23a) (Type,	Print) JAT	INDER	2 . 5	5	Stick	010		
		30. Name and address of person who 2401 Re.	search	Blu	d #	102	Rock	ville	M	D 20	6-20		
Sta	te		ami Biodian		ure	Sparks							
Registra	ar	JUN 23 199	y pre	رمر	Ø.	sporks							

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State of Maryland / Department of Health and Mental Hygiene

21630

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	Dhuala	1	1. Decedent's Name (First, Middl	e, Last)						2. Dete of Month	Deeth	Veer	3. Time of Death	
1 - 1 / 2	Physic /Medi		Samuel D. Tone	r						JUN	= 22	1999	4:45 PM	
	Exami		4a. Facility Neme (If not institution	n, give street end r	num <i>ber)</i>				4b. City, Town	, or Location of De	eth 4c. Cour	ty of Deeth		
A	- Adiiii		Doctors Communi	ty Hospi	tal			1	Lanham		Prine	ce Geo	roets	
			5. Social Security Number	6. Sex	7. Age (In y	re lest hirth	rday) if U	nder 1 Year		Hrs. 8 Date of			leca (Stete or Foreig	
	Funeral		306-30-3220	1√2 M 2 □ F			rs. Mon			Min. (Month,	Birth Day, Year) 13,1927	Indi	try)	
	Director		Usuel Residence of Decedent	**						Aug.	13,1921	IIIdI	alla	
	B		10a. Stete 10b. County		10c.	City, Town	or Location					10	0d. inside City Limits	
	ahov ahov ed.at	5											1 ☐ Yes 2 ☒ No	
1	the Maryla 28a-f sho notified at	oct	Maryland Prince	George	s Co	ollege								
(2)	5 6 8	Director	10e. Street and Number					. Zip Coda			10g. Citizen o	f Whet Count	try?	
2	23 th	100	9249 Limestone	Place			2	20740			USA			
20	S E	Funeral	11. Meritel Stetus	12. Was De	ecedent Ever in Forces?	u,S.	13. Wes D	ecedant of H	lispanic Origin	? (Specify Yes or uarto Rican, etc.)	No- 14. R	aca - America		
20	a and		1 ☐ Navar Marriad 2 ☐ Marr		s 2 No			s 2X No		darto i licari, etc./		eck, White, a		
02	2 hours atural, cel Exa	by	3 Widowed 4 Divorced	Yeer or	Detes: 194	47-55	ILL YE	es ZAJNO	Specify:		Spec	My: Whit	C	
03	2 h	Completed	15. Deceden	t's Education		16a. D	Decedent's	Usuel Occup	etion		16b. Kind of	Business/Ind	lustry	
5 5	Mad -	ple	(Specify only higher Elementary/Secondery (0-12)	T	a) (1-4or 5+)	- 7	life. DO NO	of work done OT use retired	during most of	National Bureau o				
82	the the	E	Liomontary/occordory (0-12)	5+	(1-401 54)	Ch	emist	:			Standa	ards		
OP	新	BeC	17. Father's Name (First, Middla,	Last)		,			18. Mother's	Neme (First, Midd	fle, Meiden Sume	ema)		
land	o e d be	To B	Clarence Toner						Susan	Gollaghe	r			
LU E	M by man	-	19e. Informent's Name/Reletions	hin (Tyne Print)		19h I	Mailing Ado	tress /Street				n State 7in	Code	
₩ W	d d 2 a f		Phyllis E. Toner / Wife 9249 Limestone Place, College											
€ 5	1 and Health Im 27 ther t		20e. Method of Disposition	, , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		b. Plece of C			c I Iace	Date	20c. Location			
SHM	報うなる		1 Burial 2 Cremetion	3 Ramoval from	m State	cemetery,	, cremetory	or other plea		- 0 =				
뜻들	antmen ortant: Injury		4 ☐ Donetion 5 ☐ Other (S	pecify)	Gá	ate of	Heav	ren Cei	metery	June 25	Silver	Sprin	g, MD	
() E	Departiment important in particular in parti		21. Signature of Funeral Service	Licensee				e and Addre		77	1 77			
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12			23a. Part1 Enter the diseesa, or shock, or heart feilure. List	complications that	t caused the d	eath. Do no							Approximete	
	Physician		shock, or heart feilure. List	only one ceuse or	n each line.								Onset end Death	
- 62	/Medicai		Immediate Cause (Final	М.			C .	4.4		,	11	. ,	7 . 41	
	Examiner		diseese or condition resulting in deeth)	e. 716	rigna	ncyo	T U	1K400	n orig	jin with	, Mult	John	3 mouth	
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	pet tisu	Examiner		b. To	ci of	-	.tast	000	to 6	·ne				
	end end	Xai	Sequentially list conditions, it eny, leeding to immediate		Due to	o (or es e co	1192132							
09	be e ician buris	alE	ceuse. Enter Underlying Ceuse (Diseese or Injury	o ch	ronu	065	truc	true	pulm	nango	Viscan		6-8 years	
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9 ×	ing i	an/Me												
Bo	tend or us			U										
	the ette	Physici	Part II. Other significant condition	ns contributing to	death but not	resulting in t	tha underly	ing ceuse giv	ren in Pert I.	23b. D	id tobacco use o	ontribute to	the cause of death	
P.O.	by t	Phy								1	Yes 2 No	3 Prob	ably 4 dnknow	
	The law requires thet the death ate has been signed by the etter pege 2 should be deteched for t	by												
Division of Vital Records,	auire oid bio									24e. W	es en eutopsy		ere eutopsy findings	
္မ	w requ	Completed								ре	rformed?	con	eileble prior to nplation of ceusa death?	
Be a	has ge 2	E											-	
<u>a</u>	cate									1[Yes 2 No	1	Yes 2 No	
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	dolan: The	Be	25. Was cese referred to medicel exeminer?	Hospital:				0.1		Deeth (Check onl	y one)			
5	Attending Physician: r deeth. ector: After this certific by the funeral director,	မ	1 Yes 2 No	1 6		□ ER/Outp		DOA Oth	4 LI Nursi	ng Home 5□ Re)	
5	ding P. After I	on:	27. Menner of Deeth 1 ☑Neturel 5 ☐ Pendin	28e. Det	e of Injury onth, Dey Year	28b. Tir	ne of ury	28c. injur Wor	y et k?	28d. Describ	e how injury occ	urred		
0.0	deeth deeth stor: A y the fi	cati	2 ☐ Accident investig	gation			М	10	Yes 2 □ No					
Ξ	rect rect	Ę.	3 ☐ Suicida 6 ☐ Could i 4 ☐ Homicide determ	ined 206. Ple	ce of Injury - A	t home, fern	n, street, fe	ctory, office		28f. Location City or	(Street end Nur rown, Stete)	n <i>ber</i> or Rural	Route Number,	
	rs at	Certification:			(-)						-/			
	hou hou		29a. Certifier 1 Certifyin	g Physician: To the	he best of my l	knowledge, d	deeth occur	rred et the tin	ne, dete end p	lece, end due to th	ne ceuse(s) end r	nenner es st	eted.	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	one) 2 Medical	Examiner: On the end me	basis of examenner steted.	metion end/	or investige	stion, in my o	pinion, deeth (occurred at the tim	e, date end place	e, end due to	tne ceuse(s)	
	To the Total	Σ	29b. Signeture end title of certifie					29c. Licens	e number		29d. Date sign			
	4		Routan	Family		Mn		D	4344	4	6/	23/90	7	
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State Registrar

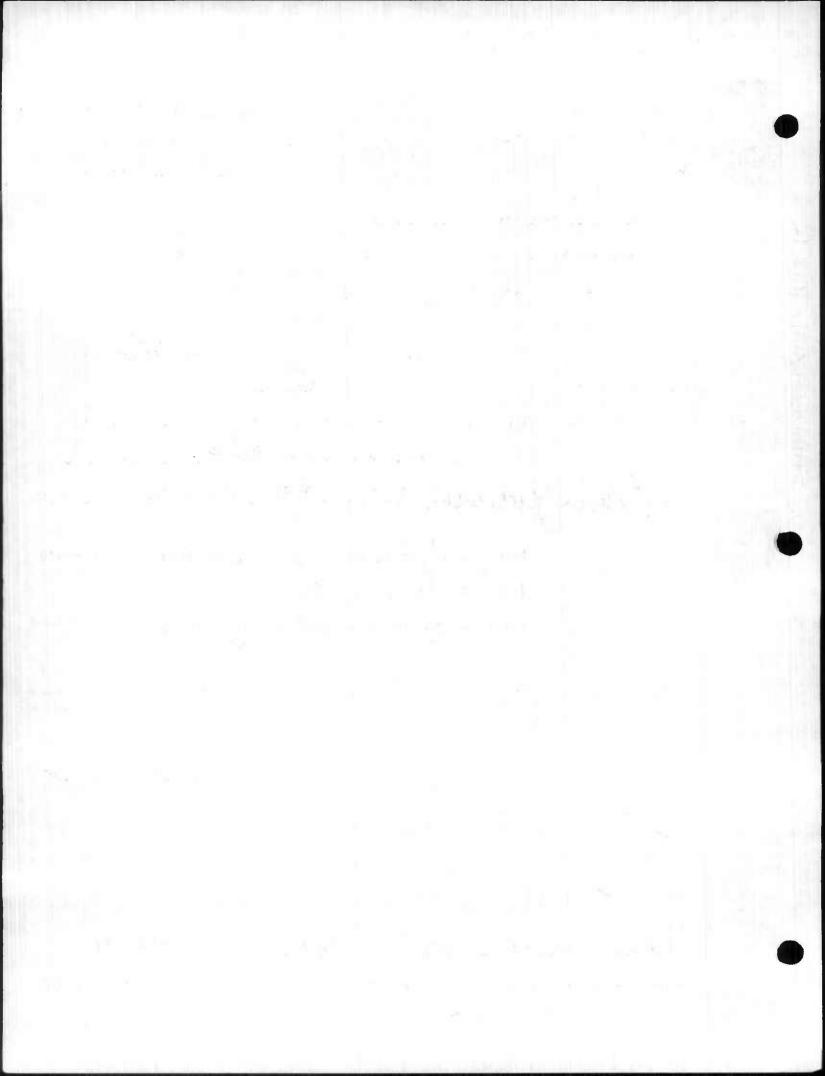
JUN 2 5 1999

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

ROINTAN FARAHIFAR 4000 M: Hebble ville voad 8216 Bowie MO 20716

31. Dete filed (Month, Dey, Year)

32. Registrer's Signature



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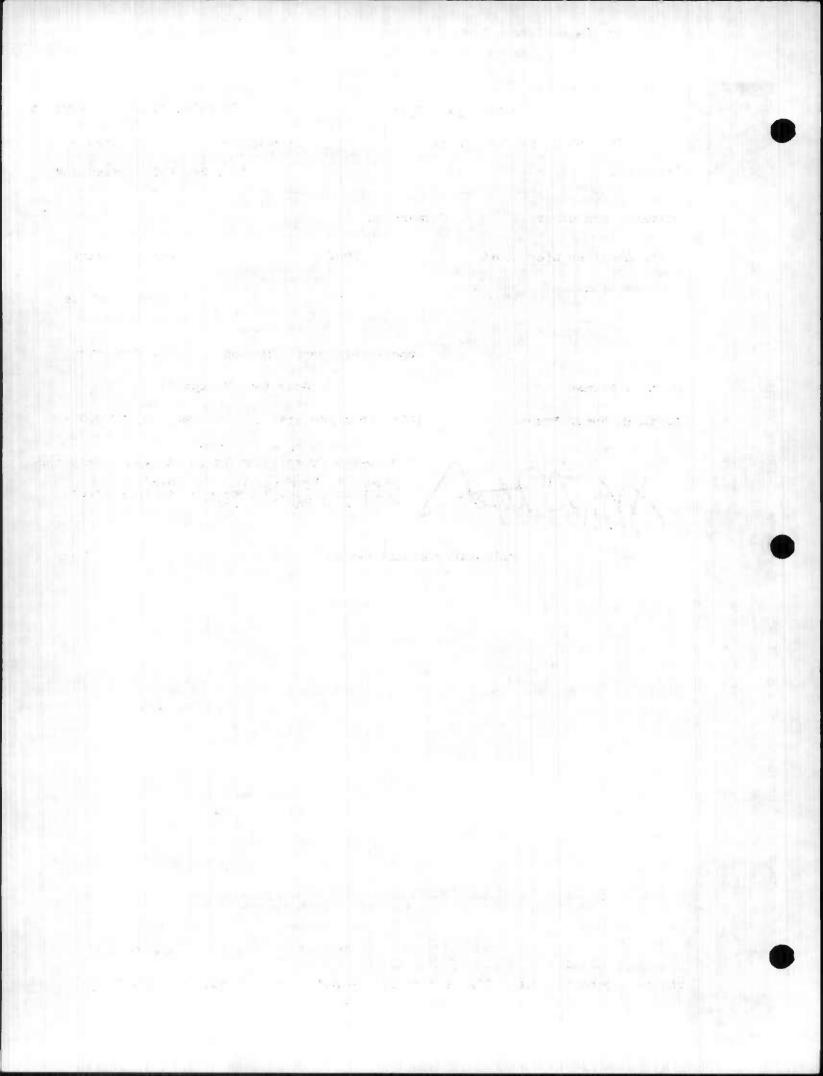
State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Data of Daath 3. Time of Death 1. Decedent's Nama (First, Middle, Last) Day Month **Physician** June 20, 1999 1:03 pm JoAnn Regina Tyma /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner 18916 Shooting Star Court Germantown Montgomery if Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar Birthplaca (Stata or Foraign Country) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) **Funeral** 1□M 2XF Months Days Yrs. 212-50-7277 46 Dec. 24, 1952 Maryland **Director** Usual Rasidanca of Decedant the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. fnside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic svent, the Medical Example, must be northed at 1 Yes 2 No Maryland Montgomery Germantown Directo 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 20874 United States 18916 Shooting Star Court death Funeral 12. Was Decedent Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Give Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. If them 27 is marked other than "naturel", or iten any Injury or other traumatic axes. Biack, Whita, atc. 1 □ Naver Marriad 28 Married Maryland 21215-0020 1 Type 2 No Specify Specify: à White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elemantary/Secondary (0-12) College (1-4or 5+) State Government 5+ Supervisory Social Worker 18. Mothar's Nama (First, Middla, Maiden Surnama) 17. Father's Name (First, Middle, Last) Be John P. Harman Genevieve Fitzpatrick 2 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. fnformant's Name/Ralationship (Type, Print) 18916 Shooting Star Ct., Germantown, MD 20874 David E. Tyma/ Husband Baltimore, 20b. Placa of Disposition (Nama of cematary, crematory or other placa) June 21, 1999 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Montgomery Crematorium Inc. Bethesda, Maryland Rockville, Maryland 20850

o not anter the mode of dylng, such es cardiec or respiratory arrest, 21. Signature of Funeral Service Lice MOOF a, or complications that caused the death Approximate Interval Between Onsat and Daeth **Physician** /Medical Immedieta Cause (Finel disaasa or condition rasulting in daath) Metastatic Breast Cancer 9 years Examiner Dua to (or as a consequence of): Examiner sician and burial-transit certificata be axecuted Sequantially list conditions, if any, laeding to immediata cause. Enter Underlying Causa (Disaasa or injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of): Box 68760. physician Physician/Medical the Dua to (or as a consequence of) 88 950 23b. Did tobacco use contribute to the cause of death? Part It. Other stanificant conditions contributing to death but not resulting in the underlying causa given in Part I. Records, P.O. 1 ☐ Yee 2 ☑ No 3 ☐ Probably 4 ☐ Unknown signed b 2 24b. Wara autopsy findings eveilabla prior to Completed 24a. Was an autopsy peen completion of cause of death? The law page 2 s 1 Yas 2 No 1 Yas 2 No certificate Division of Vital or Attending Physician: funeral director. Be 25. Was casa rafarred to medical 26. Plece of Daath (Check only ona) Other: 4 Nursing Homa 5 28 Rasidenca 8 Othar (Specify) Hospital: L_o 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? After 5 Panding invastigation 1 Natural after death. 1 Yes 2 No 2 Accidant 6 Could not be datarmined 3 ☐ Suicide 28a. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital edical 29a. Cartifiar 1 Cartifying Physician: To tha bast of my knowledga, daath occurred et tha time, deta and place, and dua to tha causa(s) and manner es stated. (Check only one) 2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the causa(s) and manner stated. To the I within 2 29b. Signetura and title of cartifiar 29d. Data signed (Month, Day, Year) 29c. Licanse number Experience or of D42452 June 21, 1999 30 30. Neme end address of person who complated causa of deeth (Itam 23a) (Type, Print) Chitra Rajagopal, M.D. 18111 Prince Philip Drive, Olney, Maryland 20832

State Registrar 31. Data filed (Month, Day, Year)
JUN 23 1999

32. Registrer's Signetura

B. Sparls



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q 216

					Cer	tificate of	Death	Re	g. No.) (. 100	6
	Physicia	an	1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month 12	P#999	Year	3. Time of	
	* /Medic		VRSS1R	MAE	1454	er	at O't Town and				3:00	am
	Examin	er	4a Facility Name (If not Institution, give	^^	06	tasio	4b. City, Town, or L	LA O	4c. County		\$A	
	Funeral		5. Social Security Number 6.5	Sex 7. Age (In yr	s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthp	place (State o	r Foreign
	Director			IDM 24DF 72	Yrs.	Months Days	Hours Min.	Septh, Pg.	1926	Meour	ntry)	
	yland		10a, State 10b. County Md Garre	10c. (City, Town or Loc Kiyzmi	ation				1	0d. Inside Cit	
	Paris de Mar	ctor	nd ouric		112)						1 XYes	2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health marked other than "paturet", or items 23a or 28a-f show any Injury or other traumatic event, "a Medical Examinar must be notified at other. Defice.	Funeral Director	10e. Street and Number 1201 Homeste	ad		10f. Zip Code 2153	3	10	g. Citizen ot \USA	What Cour	ntry?	
	dea Final	iner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U,S. 13. V	/as Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-		e - Americ		
21215-0020	ours after	Completed by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No It Yes, Give Year or Dates:		□Yes 2□No			Specify	ck. White, Whit y:	е	
5	72 h	etec	15. Decedent's E (Specify only highest gra		16a. Decad (Give	ent's Usuai Occu kind of work done	pation during most of world)	king 1	6b. Kind of B	usiness/In	dustry	
121	should be filed within nd Mental Hygiene. marked other than " umatic event, the Me	Idm	Elementary/Secondery (0-12)	College (1-4or 5+)		io not use retire Homemake			Domes	stic		
9	filed with Hygiene ther thai	ပ္	17. Father's Name (First, Middle, Last)			18. Mother's Nem	ne (First, Middle, M	aiden Suman	ne)		
au	Mental I Merked of arked of	To Be	Andrew Sims				Paulin	e Davis				
Maryland	and Marian	-	19a. Intormant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Stree	t and Number or Ru	ral Route Number,	City or Town,	State, Zip	Code)	
	1 and 2 Health a am 27 is ther trai		Daniel Tasker		Rt	l Elk G	arden,W.V	a 25717				
Baltimore,	permit. Pages 1 a Department of Hec Important: If item any injury or othe		20a. Method of Disposition 1 ☎ Burial 2 ☐ Cremation 3 ☐		Placa of Dispos cemetery, crem	sition (Name of natory or other pla	ice)	Date 2	Oc. Location	City or To	own, State	
Ĕ	Pages ment of ant: If its lury or o		4 Donation 5 Other (Special		Mt. Zio	n Cemete	ry J	une 17'99	Mt.Z	ion M	id	
Sall	permit. Departr Importu any Inje		21. Signature of Funeral Service Lice	nsee	22.	Name and Addre David, A	Burdock	FH		0150	.0	
	005 8 8		Hard 11-	Durdock						2153	8	
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the de one cause on each line.	ath. Do not ente	er the mode of dy	ng, such es cardiac	or respiratory arre	st,		Approximate Intervel Bets Onset and I	ween
À	Physician /Medical		Immediate Cause (Final	0 10		1	1500				0 1 0	
201	Examiner		disease or condition resulting in death)	a Yarkin		5 (1269	>4		1	Jea	LVS
		ner		Due 10	(or as a conseq	derice ot):						
	icate be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions,	b. Due to	(or es e conseq	uenca ot):						
0,	e exe	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0								
68760,	cate b	dica	that Initiated events resulting in deeth) Last	Due to	(or as a consequ	ience ot):						
9 ×	ding g	5		d						i		
Вох	leath certifica attending pl	cian										
P.O.	the d	Physician/	Part II. Other significant conditions of	,			ven in Part I.	235. Did to	_ /		o the cause of bably 4 -	
٣,	s that	y P	lespira	story ra	ILVE	?		10.74	* 2LJ/NO	30110	bebly 4	Olikilowi
Vital Records,	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by						24a. Was an perform	autopsy ed?	av cc	era autopsy t vailable prior to empletion of c	0
Re	has b has	dmo						1□ Ye	2 No		death? □Yes 2□	No
ta	iclan: The law certificate has rector, page 2	Be Co	25. Was case reterred to medical				26 Place of Dea	ith (Check only one			nies sn	140
5	ysicle s cert direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 11 Inpatient 2	☐ ER/Outpatien	3□ DOA OI	hor	ome 5 Resider	0.00	ner (Specia	fy)	
0	g Physical dispersion		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Inju	ry at	28d. Describe ho	w Injury occur	rred		
Division of	Attending Physician: r death. sector: After this certific. by the funeral director,	Certification:	1 Natural 5 Pending Investigatio	n	injuty		Yes 2□No					
Š	r Atter de lirecte	T T	3 Suicide 6 Could not be determined	28e. Placa of Injury - At building, etc. (Spe		et, tactory, office		28t. Location (Str. City or Town,		ber or Run	al Route Num	iber,
۵	illed i	S									7.2.2	
	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical		nysician: To the best of my kinner: On the basis of examinand manner stated.								i)
	ithin of the omple	Z e	29b. Signature and title of cartifier	and manner stated.		29c. Licen	se number	29	d. Date signe	ed (Month,	Day, Year)	
	P 5 P 6		1 Mans	mor		1-1	-2619	5-4	6/1	5/	99	
			30. Name and address of person who	completed cause of death (It	em 23a) (Type. I	Print)	24/	10	0 1	10	1	
	È	*	69 Wal	Re CLCV	05	DVIV	re Oa	Momo	N	N(1)	CIST	0,0
	Stat	_	31. Date tiled (Month, Day, Year)	32. Registrar's Sig		1	A. 1					
	Registra	ar	JON I 6.3	999	p.	4000						

DHMH 16 Rev 6/95

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A	mend_#1.	Per Phys. 1	PGC 6-25-		Maryla		rtment of tificate of	Death	mental Hy	Reg. No.	9 2	633
	Physician /Medical	1. Decedent's Name Doris	(First, Middle, Las Jean Joan	y Vinson					2. Date of Do Month June	Dey 1999	Year	Time of Deeth: 35 A.M.
	Examiner	4a Facility Name (h 3821 Wal	not institution, give		nber)			4b. City, Town, or Forestvi			of Death e Georg	ge's
	Funeral Director	5. Social Security N 578-78-50	82	x □ M 2Å)F	7. Age (In yrs 43	: last birthday) Yrs.	If Under 1 Yea Months Days		8. Dete of Bi Month, Di June 2	iv. Year) 5, 1955	9. Birthplace Country) Washing	(State or Foreign
	show dat	Usual Residence of 10a. State	10b. County			ity, Town or Loc						Inside City Limits
	o M	Maryland	Prince Ge	orge's	PC	orestvi]	_					
	besth with the Marylar res 23e or 28e-f show must be notified at reral Director	10e. Street and Nun 3821 Wa1	_{nber} ters Lane				10f. Zip Code 20747			10g. Citizen of W United		
020	ar, or the Examiner by Fur	3 ☐ Widowed	ed 2 Merried	12. Was Dece Armed For 1 Yes If Yes, Give Year or Da	ces? 2 No		Vas Decedent of Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puerl o Specify:	pecify Yes or No o Rican, etc.)	14. Race Bleck Specify:	- American Ir k, White, etc.	
21215-0020	ed within 72 ho ygiene. er then 'netur t, the Medical. Completed	(Specification) (Specification		ucation le completed) College (1-	4or 5+)	(Give I	O NOT use retir	e during most of wo		16b. Kind of Bu		У
9		17. Father's Neme				161301	mer sec			, Maiden Sumem		
Maryland	Mental H Mental H arked off arke ever	T						Laura E		, maion obnioni	,	
	nd 2 sho lift and 27 is me r traum	19e. Informent's Ne Charles A	me/Raletionship (T. Vinson,		Husband			tane Fore				le)
Baltimore,	ges 1 ar If Item 3 or other		☐Cremetion 3 ☐I		itate		atory or other pi		Date (0.0	20c. Location	•	
=	family dury		5 ☐ Other (Specify,		l Ha		[emorial	L	6/25/99	Landov	er, ma	ryland
Ba	Depa Impo any is	21. Signature of Fu	M. H	awt	3	ΛΛ	Name and Add	Staing Road,	ewart F N.E. W	uneral H ashingto	ome, I	nc. . 20019
	Physician	23a. Part L Enter the	e disease of comp t leilure. List only o	lications that ca ne cause on ea	used the dea ich line.	ith. Do not ente	r the mode of dy	ring, such as cardia	or respiratory a	rrest,	Apr Inte On:	proximate ervel Between set and Death
	/Medical Examiner	Immediate Cause (disease or condition resulting in death)	Finel	a	Due to	or as a consequence	aluci pence of):	s Jun	gca	ncer	9	mos
98760,	physician and street but street the buriel-transit	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events		c		or as a consequ						
Box 68	at the death certificated by the attending phystached for use as the Physician/Medi	resulting in death) L	L	d								
	death od for	Pert II. Other signifi	cant conditions co	ntributing to de	ath but not re	sulting in the un	derlying cause o	given in Pert I.	23b. Did	tobacco una con	tribute to the	cause of death?
P.0	ss that the de igned by the be detached by Physical by								1/2	Yes 2□ No	3 Probebl	y 4□Unknown
Records,	aw requires to been s 2 should pleted									en eutopsy ormed?	availab	autopsy findings ble prior to ation of cause th?
8	The Late has page								10	Yes 2 No	1 □ Ya	s 2 No
VItal	certificate rector, pa	25. Was case referr	ed to medical					26. Place of De	eth (Check only	one)		
2	0 0 0	1□ Yas 201	No	Hospital: 1 🗆 tr	patient 20	ER/Outpatient	3D DOA	ther: 4 Nursing H	tome TRes	idence 6 Othe	or (Specify)	
ion of	Attending Phirideath. setor: After thi by the funeral	27. Manner of Death 1 Natural 2 Accident	5 Pending investigation	28a. Dete o (Montf	f Injury o, Day Year)	28b. Time of Injury	28c. Inj W M 1[ury at ork? Yes 2 No	28d. Describe	how injury occurr	ed	
Division	tal or Attanding P is after death. al Director: After bed in by the funeri certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place building	of Injury · At I g, etc. (Spec	nome, larm, stre	et, lactory, office	В		(Street and Numbe wn, State)	er or Rural Ro	uta Number,
	To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b Medical Certif	29e. Certifier (Check only one)	Certifying Phy	sician: To the to ner: On the ba- and mann	sis of examin	owledge, death ation and/or inv	occurred at the estigation, in my	time, data and place opinion, death occu	, and due to the urred at the time,	cause(s) and ma data and place, s	nner as stated and dua to tha	f. cause(s)
	To the Vithin To the comp	29b. Signature and	tite of configur	ale			29c. Licer	nse number		29d. Date signed	Month, Day,	Year)
	15)	30. Name and address	ss of peesign who o	DAL	of death (Ite	m 23a) (Type, F	Print) (P)	y Dan	and	V	161	
	State Registrar	31. Dete filed (Mont	n, Day, Year)	32 Re	gistrar's Sign	sature 6.	boils		1000	**		

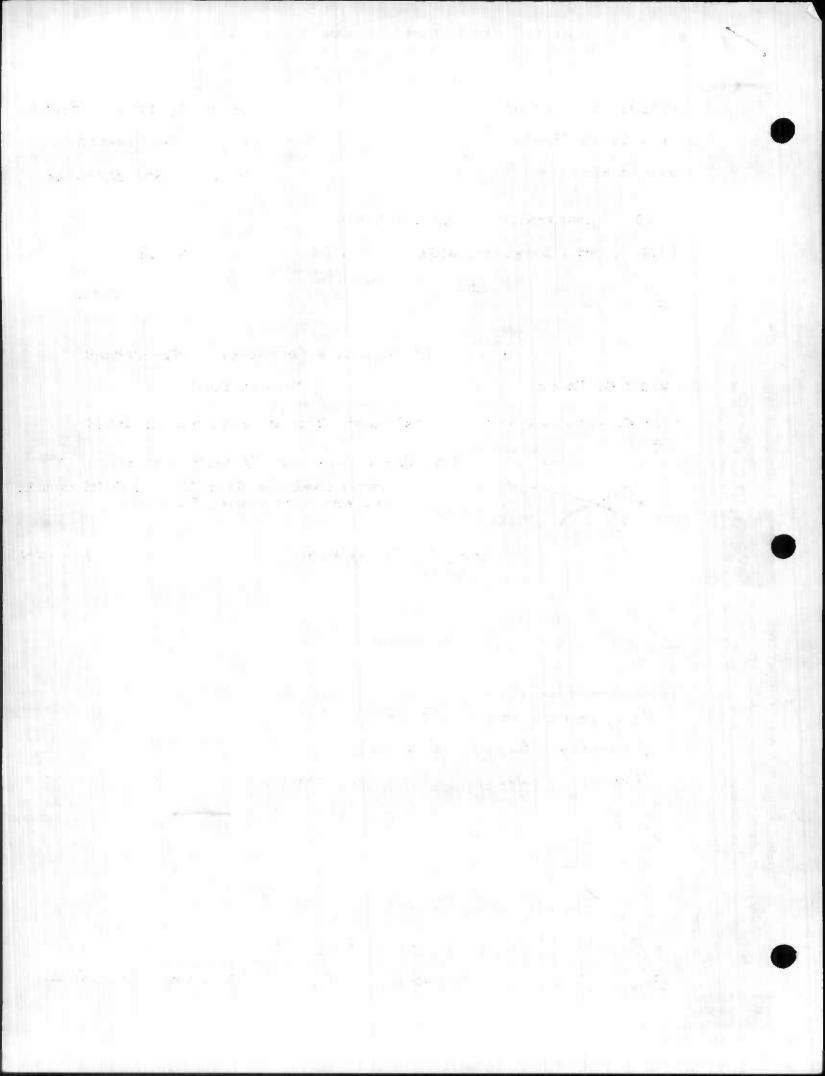
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Ell's in

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #26,6/23/99,BMW,Montg.Co. Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Day Yaer **Physician** Frances W. Wissner June 15, 1999 10:00PM /Medical 4b. City. Town, or Location of Daath 4e Facility Nama (If not Institution, giva street and number) 4c. County of Death Examiner 9441 Tobin Circle Potomac Montgomery If Undar 1 Year | If Undar 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthdey) Birthplaca (Stata or Foreign Country) **Funeral** 1□M 2**X**F Months 314-16-6661 Yrs. 92 Director Dec. 1, 1906 Oklahoma Usual Rasidenca of Decedent with the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits ris marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar mast be notified at 1X Yes 2 □ No Silver Spring MD Directo Montgomery 10e Street and Number 10f. Zlp Coda 10g. Citizen of What Country? 3701 International Dr. #531 20906 U.S.A pemit. Pages 1 end 2 should be filed within 72 hours after death v Department of Health end Mental Hygiene. Important: If frem 27 is merked other than "natural", or frems 23a any Injury or other traumatic event, the Medical Exercities man abonce. Funeral 12. Was Decedant Ever in U,S.
Armed Forces?
1 ☐ Yes 2 2 No
If Yas, Giva
Yaer or Detas: Was Decedant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuben, Mexicen, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Nevar Married 2 Married Specify: White 1 Yes 2 No Specify: 3. Widowed 4 □ Divorced by Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Elamentary/Secondary (0-12) College (1-4or 5+) Accountant & Secretary Government 18. Mothar's Nema (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Edgar C. Knope Frances Ford 19b. Mailing Addrass (Straet and Number or Rurel Route Number, City or Town, Steta, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Mary F. Vito-Daughter 9441 Tobin Circle, Potomac, MD 20854 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 20b. Place of Disposition (Name of cematary, crametory or other placa) 20c. Location - City or Town, Stala 4 □ Donation 5 □ Other (Specify) Rock Creek Cemetery 6/18/99 Washington, DC 22. Nama and Addrass of Facility
Joseph Gawler's Sons INC, 5130 Wisconsin 21. Signeture of Funaral Sarvica Licensee Ave. NW, Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdled or respiratory errest, shock, or feen failure. Lisbonly one cause on each line. Approximata Interval Between Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) 9 months Pulmonary Neoplasm Examiner Physician/Medical Examiner attending physician and for use es the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Dua to (or as a consequence of): rasulting in daath) Last 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 3 Probably 4 Unknown 1 Yes 2 No Heart Failure Congestive by Coronary Artery Disease 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed compiation of ceuse of death? i certificate has b Chronic Obstructive Pulmonary Diseak 1 Yas 2 No 1 Yes 2NNo Hospital or Attending Physician: 25. Was cese refarred to medical axaminar? director, 26. Placa of Deeth (Check only ona) Be Othar: 4 Nursing Homa Canadama 6X Othar (Specify) residence Hospital: 1 Yes 2 No ၉ 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred 27. Menner of Death 28c. Injury at Work? Certification: After 1 Naturel 5 Panding n 24 hours after death.

Funeral Director: After oletely filled in by the fur 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At home, farm, straat, factory, offica building, atc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, data and place, end dua to tha causa(s) and mannar as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. within 2 120 29d. Data signad (Month, Day, Year) 29b. Signature and title of certifian 29c. Licensa number 2 June 16, 1999 n Broderick M.D 30. Name and addrass of person who completed ceusa of daath (Itam 23a) (Type, Print) of death (Ilam 23e) (Type, Print) 18111 Prince Philip Dr. TIZ Olney, MD 20832 Broderick 31. Data filed (Month, Day, Year)
JUN 2 3 1999 32. Registrar's Signatura

State Registrar



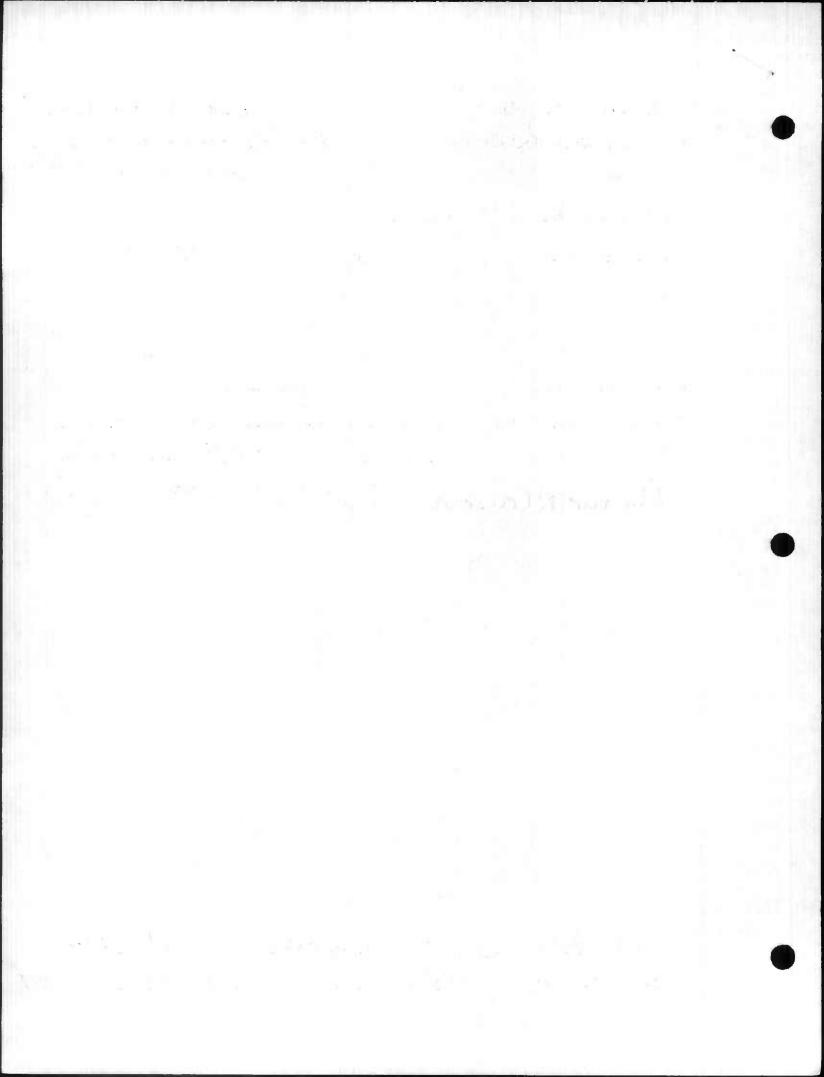
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State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 11:45AM WALLACE LLIAN NUNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FORT WASHINGTON HOSPITAL FORT WASHINGTON PRINCE CTEURGES If Under 24 Hrs. Hours Min. If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) V1CTOTIA **Funeral** Months Days 1□ M 20XF 82 228-22-4778 Yrs. Director 6,1917 Virginia Usual Residence of Decedent death with the Maryland 10e. State 10c. City, Town or Location 10b. County 10d. Insida City Limits 28a-f show item 27 is marked other than "natural", or items 23s or 28s-f show other treumsite event, the Medical Examiner must be notified at Virginia Lunenburg Victoria 1 X Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? United States 10f. Zip Code 922 Lunenburg Avenue 23974 of America Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Maritel Stetus permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other treumatic event, the Medical Examined once. 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yea 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupstion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind ot Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker OwnHome 17. Father'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Charles Warren Ogburn Otelia Smithson 2 19a. Informant's Neme/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles D. Akins/Brother-In-Law 12002 Hunterton Street, Upper Marlboro, MD 20774 20b. Place of Disposition (Name of cemetery, cremetory or other plece) June 25 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremetion 3 Removel from State East End Cemetery Victoria, Virginia 1999 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee #M00690 22. Name end Address of Fecility S.P. Jones & Son Funeral Home 23944 auson 208 North Broad Street, Kenbridge, Virginia 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory arrest, ahock, or heart tailure. List only one cause on each line. Approximate Interval Betw Physician Massive Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examiner ician and burial-transit Sequentielly liat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of) physician s the burial Box 68760. eds Physician/Medical Due to (or as a consequence of) 88 950 jo Division of Vital Records, P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown þ 8 The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was sn autopsy performed? Completed Deen has page 2 1 ☐ Yes 2 0 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical. 25. Was case reterred to medical Be 26. Place of Death (Check only one) examiner? Hospitel: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 funerai 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of 1 SNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 3 Suicide 6 Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated. To the To the To the I 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Pay, Year) 8 30. Name and eddress of person who completed cause ot death (Item 23a) (Type, Print) ALIKHANI LAPLATA, MD 20646 1031 WALES

State Registrar 31. Date tiled (Month, Day, Year)

JUN 23 1999

32. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

10d. Inside City Limits

Approximate tnterval Between Onset and Death

Yes 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

JUNE 17, 1999

29d. Data signed (Month, Day, Year)

1M Yes 2□No

CHARLIE	
T. TON 43 OTF	

WOMA

CK				Certificate of Death	Rej	g. No.	1000
	1. Decedent's Nama (Fire	st, Middla, Last)			2. Data of Death		3. Time of Death
Physician /Medical	Charles	Wynnes	Womack		JUNE JUNE	Day Year 16, 1999	2:05P.M.

Funeral Director

Director

Funeral

Completed

Be

28a-f show

the Medical Examiner must be notified at 6 234 death Nems filed within 72 hours after neturel', or Hygiene.

Baltimore. Maryland 21215-0020 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic avent. Physician

/Medical

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

Examiner physician and s the bunal-transit The law requires that the death certificate be executed Box 68760 P.O. signed by the Records. been signature page 2 Division of Vital or Attending Physicien: this death.

hours after death ni bellit / 24 hours Hospital pletely within 2 To the I \$ 0

4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) 803 MAURY AVE OXON HILL PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Data of Birth (Month, Day, Year) Days Months Hours **X**□M 2□F 577-70-1535 48 February 13, 1951 Pittsylvania, VA Usuat Rasidance of Dacedant 10b. County 10c. City, Town or Location Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 803 Maury Avenue 20745 United States 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2Å No If Yes, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Navar Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) nine years Collega (1-4or 5+) Engineer Private 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Obrey Taylor Womack Mary Eva Fitzgerald 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a, Informant's Name/Ratationship (Type, Print) Jimmie Lee Womack - brother 7503 Epping Ave. Ft. Washington, MD 20744 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Deta 1 ☐ Burial 2 Cramation 3 ☐ Ramovel from Stata Lee's Crematory 6/21/99 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify): 22. Name and Address of Facility 21. Signature of Funeral Service License Stewart Funeral Home, Inc. 4001 Benning Road, N.E. Washington, D.C. 20019 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, in heart feilure. List only one cause on each line. tmmediata Causa (Final disaasa or condition rasulting in death) Dua to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting to death) Last Dua to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part t. 23b. Did tobacco use contribute to the cause of death? 30 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? NZ Yas 2 No 26. Place of Daeth (Check only one) 25. Was casa reterred to medical Other: 4 Nursing Homa Nursing Homa Nursing Homa Other (Specify) 1X Yas 2□ No 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Deta of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

31. Data filed (Month, Day, Year) State JUN 2 2 1999

Natural

2 Accident

3 Suicide

29a. Cartifian

29b. Signate

4 Homicide

5 Panding

title of certifier

invastigation

6 ☐ Could not be detarmined

32 Registrar's Signatura

eted causa of death (Item 23a) (Type, Print)

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

111 Penn Street, Baltimore, Maryland 21201

1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medicat Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29c. License number

O.C.M.E.

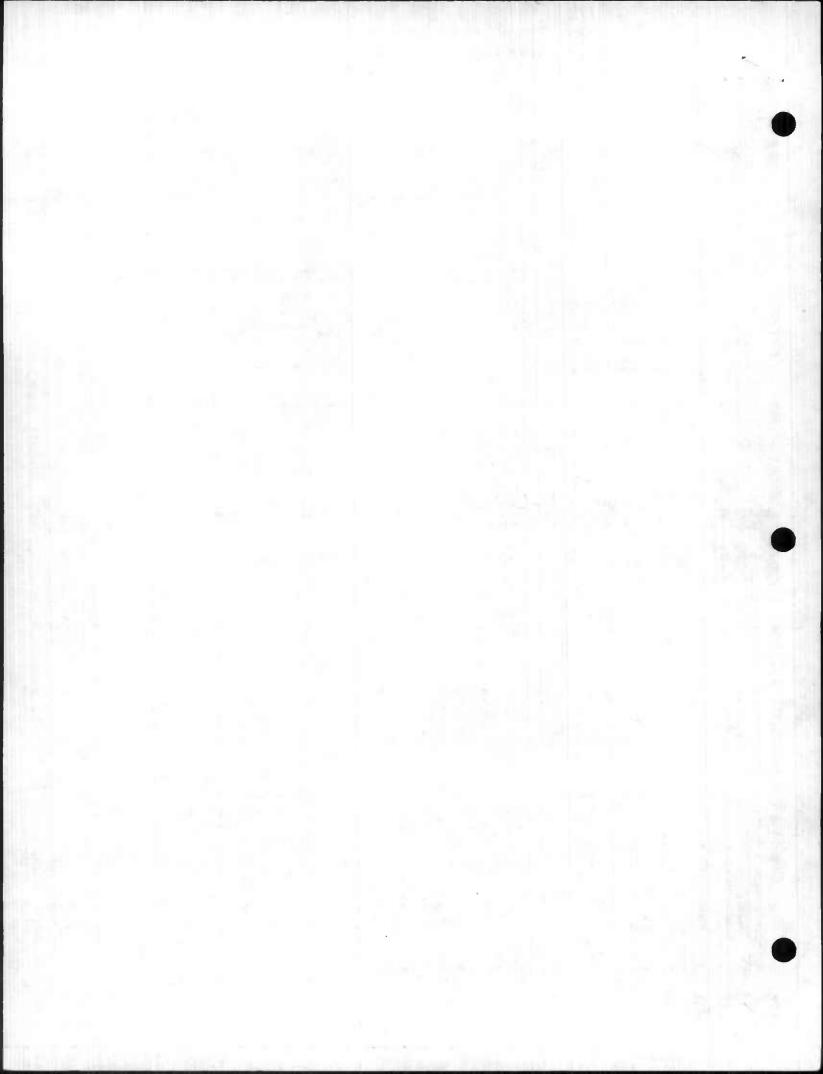
1 Yas 2 No

Registrar

2891 \$ 5 HBC

		Certificate of Death	Reg. No. 99 2 6 3 7
Div. of the	Decedent's Neme (First, Middle, Last)		ate of Death onth Day Year 3. Time of Death
Physician /Medical	BLANCHE K. WOLFE		INE 18, 1999 1:00 PM
Examiner	4a Facility Name (If not Institution, give street and number)	4b. City, Town, or Location	of Death 4c. County of Death
	SUBURBAN HOSPITAL	BETHESDA	MONTGOMERY
Funeral Director	5. Social Security Number 6. Sex 1 M 2 T F 82 82	Months Days Hours Min. (M	ate of Birth forth, Day, Year) 1. 16,1916 9. Birthplace (State or Foreign Country) NEW YORK
ahow share sd.st	Usuel Residence of Decedent 10a. State 10b. County 10c. City, MARYLAND MONTGOMERY	Town or Location CHEVY CHASE	10d. Inside City Limits 1 ☐ Yes 2 🖔 No
vith the Ma to 21a-f a be notified Director	10e. Street and Number	100 To Code	10g. Citizen of What Country?
	4620 N. PARK AVENUE #302W	10f. Zip Code 20815	UNITED STATES
ur after death val. or twee 23s Examiner must by Funeral	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Ever in U.S Armed Forces? 1 Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican,	es or No- elc.) 14. Race - American Indian, Black, White, etc. Specify: WHITE
To he market	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working	16b. Kind of Business/Industry
ed within 72 ho yglere. wer than "natur it, the Medical. Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	
D Bres	12	SECRETARY	GALLAUDET COLLEGE
Aental Hy read oth the event	17. Father's Name (First, Middle, Last) 11 UNKNOWN'I	18. Mother's Name (First	t, Middle, Maiden Sumame)
o p E E	19a, Informent's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Rou	te Number, City or Town, State, Zip Code)
212	EDDIE WOLFE (SPOUSE)	4620 N. PARK AVENUE #302	W-CHEVY CHASE, MD. 20815
ant of He art of He It If Bern y or othe	1 N Burial 2 Cremation 1 Premoval from State	ace of Disposition (Name of metery, crematory or other place) NG DAVIE MEM. GDN. 6/20	
and and and and and and and and and and	21. Signature of Funeral Septice Ligensee		
Page 1	100	22. Name and Address of Facility EDWARD SAGEL FUNERAL D	DIRECTION, INC.
-	234 Part 1 Enter the disease or complications that caused the death	Po not enter the mode of duing such as cardiac or near	ROCKVILLE, MARYLAND 20852
Navalaian Navalaian	23. Part1. Entay the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.		Interval Between Onset and Death
hysician /Medical	Immediate Cause (Final	1	10 . 4
Examiner	disease or condition a. Carampul	monary arrest as a consequence on: bral hemorrhage	10 minutes 7 days. Unknown
- b	Due to (or	as a consequence of:	2 1.
nash m		as a consequence of):	Tolays.
physician and s the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	as a consequence of):	174
क हिंद		alhy	unknown
grid 🕳	resulting in death) Last	as a confequence of):	
ed by the attending detached for use	Part II. Other eignificant conditions contributing to death but not result	lting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?
gned by the be detache by Phys	Dissecting acrtic anew	ysm	1 Yes 2 No 3 Probably 4 Unknown
w requires that been signed t should be det			4a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause
has has			of death?
This certificate rai director, page TO Be CO	25. Wes case reterred to medical	26. Place of Death (Che	ock only one)
direction of	examiner? 1 Yes 2 No Hospital: 15 Inpatient 2 E	Pr/Outpatient 3□ DOA Other: 4□ Nursing Home	S Residence 6 Other (Specify)
th. After this funeral di			Describe how injury occurred
tal or Attending P is after death. at Director: After led in by the funera Certification:	a Could not be		ocation (Street and Number or Rural Route Number, ity or Town, State)
To the Heaptal or Attending Philip 24 hours after death. To the Fureral Director: After th completely filled in by the funeral Medical Certification: Medical Certification: 7	(Check only 2 Medical Examiner: On the basis of examination	riedge, death occurred at the time, date and place, and do on and/or investigation, in my opinion, death occurred et t	ue to the cause(s) and manner as stated. the time, data and place, and due to the cause(s)
thin 2 mplet	and menner stated.		
1 00 00 Z	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
7/	Llan Lrong	D42786	6/18/99
	30. Name and address of person who completed cause of death (Item 2) 11.4N 1RONY 5225 POO	23a) (Type, Print) 2KS HILL RD. #1 BETHES	DR MD 20814
State	31. Date filed (Month, Day, Year) 32. Registrar's Signatu	we /. /	*
Registrar	JUN 2 1 1999 Show	B. Spark	

Wolfe, Blanche K. W/18/99 1300



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	4 0	457	43						Reg. No.		0 Ti 17
Physician		ne (First, Middle, Las						2. Dete of De Month	Dev	Yeer	3. Time of Death
· /Medical	CHARLES		VILLIAMS						24,1999		1:24am
Examiner		(If not institution, give					4b. City, Town, or L				
		BOA AVENU		#	Cara If Hod	er 1 Year	CAPITOL If Under 24 Hrs.				
neral ector	5. Social Security I 231-34-2	630	7. Age	(In yrs. lest	Yrs. Months			8. Dete of Bir NOV24,	1928	POR	plece (Stete or Foreign SMOUTH, VA
	Usuel Residence of 10e. Stete	10b. County		10c City. To	own or Location						10d. Inside City Limits
any injury or other traumatic event, the Medical Examines must be nothing at once. To Be Completed by Funeral Director	MD	PRINCE GI			OL HEIGH	TC					14 Yes 2 No
Funeral Director	10e. Street and Nu		ORGES	CAPII		ip Code			10g. Citizen of	Affron Cou	
ត់		BOA AVENUE	7		207				UNITE		
era	11. Meritei Status	2011 11121101	12. Wes Decedent Ev	rer in IIS			Hienenic Origin? (St	perify Ves or No			ican Indien,
5		ried 2 Married	Armed Forces?				Hispenic Origin? (Spoen, Mexican, Puerto	Rican, etc.)	Bie	ck, White,	, etc.
by	3 Widowed		If Yes, Give Year or Dates:		1 ☐ Yes	24 No	Specify:		Specif	y: BI	LACK
Completed	(Spe	15. Decedent's Ed	ucation de completed)	16	Se. Decedent's Us (Give kind of v	uei Occu vork done	pation during most of work ed)	king	16b. Kind of B	usiness/lr	ndustry
dm	Elementary/Sec		College (1-4or 5+)	HEMICAL			PRIVATE			
ပိ	17 Enthode Mana	(First, Middle, Last)			HEFITCAL	SUFE		PRIVALE leme (First, Middle, Maiden Sumame)			
Be		WILLIAMS					ANNETTE		CLARK		
To		lame/Relationship (7	Inna Driett		Oh Mailine Add	00 /50				State 7	in Code)
		- In the second					t end Number or Ru				p Source)
	MAKY W.	ILLIAMS /	WIFE		of Disposition (N		E CAPITOL	Deta Deta	S,MD 20 20c. Location		own State
	1 🖾 Burial 2	Cremation 3		ceme	oLN CEME	other ple		-28-99	SUITLA		
		5 Other (Specify		LINC			1	-20-99	SULILA	ND, MI	,
ouce.	21. Signeture of F	unerel Service Licen	and a						ERAL HO		
	Ler	Ta. A	wage				BORO PIKE			D2074	+7
	23a. Pert1. Enter shock, or he	the diseese, or compart failure. List only	plications thet caused to one cause on each line	he deeth. D	o not enter the m	oda of dy	ing, such es cardiac	or respiretory e	errest,		Approximete Interval Between
in al											Onset and Deeth
	Immediate Cause disease or conditi	on	METASTA	TIC G	ASTRIC C	ANCE	R			i	6 MONTHS
	resulting in deeth)		D	ua to (or as	a consequance o	f):					
line			b								
dical Examiner	Sequentially list or	onditions,	D	ua to (or es	e consequence o	f):					
E E	Sequentially list of if eny, leeding to licause. Entar Und Ceusa (Disease o	erlying r injury	C								
dica	that initiated evant resulting in deeth)	S	D	ue to (or es	e consequence of):					
			d								
Physician/M										1	
ysi	Pert II. Other signi	meant conditions co	intributing to death but	not resulting	g in the underlying	cause g	wen in Pert I.				to the cause of death?
								10	Yes 2⊠ No	3 Pro	obably 4 Unknow
d by		-						24a. Was	s en eutopsy	24b. W	Vere autopsy findings
Completed								perf	ormed?	0	vailable prior to ompletion of cause
du									У		f deeth?
									Yes 2 No	1	☐ Yes 2☐ No
Be	25. Was casa rafe examiner?		Hospitei:				26. Placa of Dea				
T.	7 Manner of Dee	1140	1 Linpatien		Outpetient 3 1	JUA	4 LI Nursing n		idence 6 Otl		ify)
Certification:	27. Mannar of Dea 1 □\text{Naturel} 2 □ Accident	5 Pending investigation	28e. Dete of tnjury (Month, Day	Year) 28t	o. Time of Injury M		ury et ork?] Yas 2 □ No	Zou. Dascribe	how injury occu	Den	
He	3 ☐ Suicide 4 ☐ Homicida	6 Could not be datarmined	28a. Piaca of Injur building, atc.	y - At homa,	farm, straat, facto	ory, office		28f. Location	(Street end Num	ber or Ru	ral Route Number,
- F	- I Hombida		ounding, atc.	(Specify)				Only of 10	, Gloto/		
edical 0	29a. Certifier (Check only	XX Certifying Phy	sician: To the best of	my knowled	lga, daath occurre	d et the t	ima, dete end piece	, and due to tha	causa(s) and m	anner as	steted.
pletely filled in by the funeral edical Certification:		Z I I MODICAL EXAM	mer: Un ma dasis of a	xamination ad.	and/or invastigatio	on, in my	opinion, daath occu-	rred at tha time,	, uate end pieca,	AND DUB	to trie causa(s)

30. Name and eddress of person who complated cause of deeth (Item 23e) (Type, Print)

MUTUMBA KANKONDE M.D. 1221 MERCANTILE LANE, LARGO, MD

State Registrar

31. Dete filed (Month, Day, Year)
JUN 2 5 1999



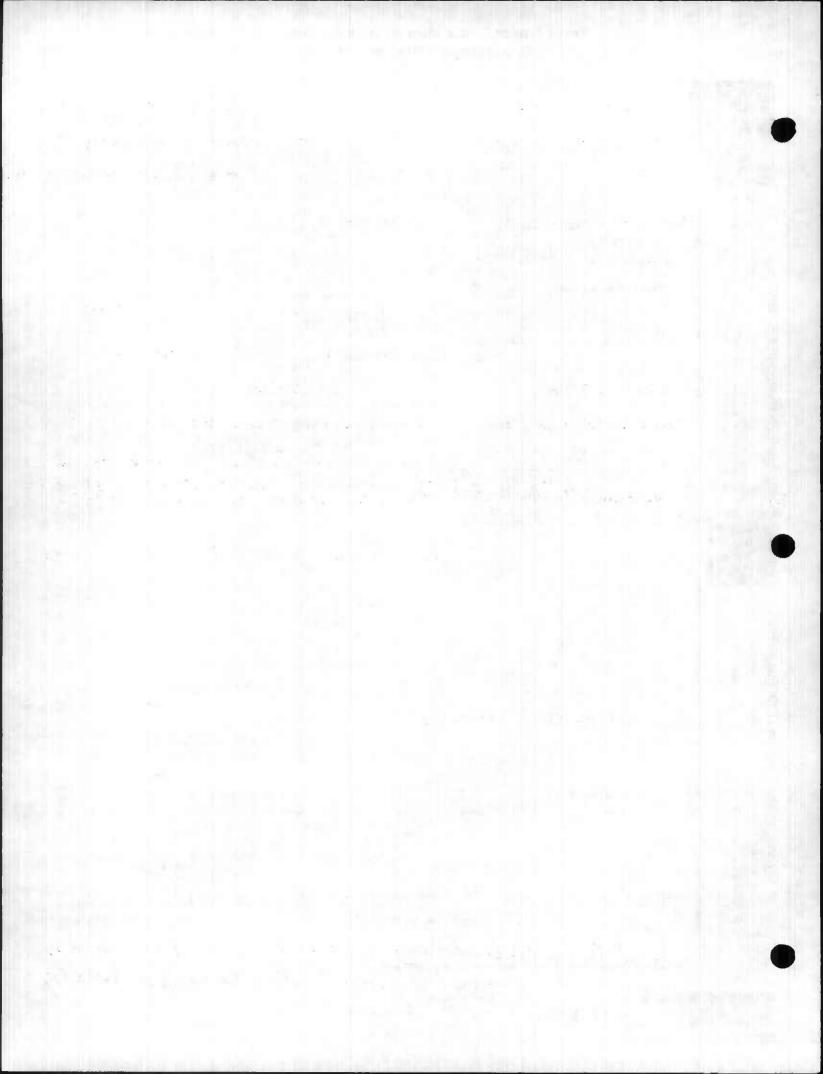
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State of Maryland / Department of Health and Mental Hygiene 9 9 2 1 6 3 9

					Certifica	te of	Death		F	leg. No.	-	1000
		1. Decedent's Name (First, Middle, Li	ist)				- 72		2. Date of Dea	th	Yaar	3. Time of Death
	Physician /Medical	Grace Barbara	Walker						June 20	Day 1999	Taler	7:45 AM
1	Examiner	4a Facility Name (If not institution, gi	ve street and number)				4b. City, Tov	wn, or Loc	ation of Death	4c. County	of Death	
		Wilson Health Ca	re Center					hers	burg	Mont	gome	ry
	Funeral Director		1□M 2KTE	(In yrs. last birth	Months	er 1 Year s Days	-	Min.	B. Date of Birth (Month, Day November	Year) 18,1918		lace (State or Foreign try) York
	Man and and	10a. Stete 10b. County		10c. City, Town	or Location						10	0d. Inside City Limits
	Mary First for	Maryland Montgom	erv	Gait	hersbu	ro						1X Yes 2 □ No
	or 28a-f s be notified Directo	10a. Street and Number	iozy .	Oult		ip Code				10g. Citizen of W	Vhat Coun	itry?
	th with	301 Russell Ave	nue, #429			208	77			United	Stat	es
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at page. To Be Completed by Funeral Director	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ender Armed Forces? 1 Yes 2 No. If Yes, Give Yeer or Dates:				Hispanic Original, Mexicen Specify:	gin? (Spec , Puerto R	city Yes or No- lican, etc.)	14. Race Blac Specify		etc.
Ş	tural rate of the	15. Decedent's E		16a. [Decedent's Us	ual Occu	pation			16b. Kind of Bu	Whi usiness/inc	
21215-0020	led within 72 hours a hygiene. The than "natural", of it, me lead a lead by	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+		Give kind of w life. DO NOT	vork done use retire	during most d)	of workin	9			
21	d with giene pr tha	Elementary/Secondary (0-12)	2	"	Homem	aker				Own Ho	ome	
nd	ould be filed Mental Hygi arked other atic event, I	17. Father's Name (First, Middle, Las	1)				18. Mothe	r's Name	(First, Middle,	Maiden Sumam	Θ)	
Maryland	2 should be and Mental is marked of sumatic ever	Howard O. Fishe	r				Bar	rbara	Hoet	jes		
Var	2 sho	19a. Informant's Name/Relationship								r, City or Town,		
6,	1 and Health am 27 Ather tr	James Forest Walker,	II / son	12	402 Gre	eat E	Park C	ircle	#103	, Germa		
Baltimore,	permit. Pages 1 Department of H Important: If Ita any injury or of pnce.	20e. Method of Disposition 1 □ Burial 2 ☑ Cremetion 3 □ 4 □ Donation 5 □ Other (Speci		20b. Place of cemetery Montgot	mery Ci	remat	orium	, Inc	1999	20c. Location - Bethesda		
Ball	Departiment Important Important Information Informatio	21. Signature of Funeral Service Lice	Mullenda	MOO831 Wunce	Robert	A. Pu	ess of Facility Imphrey sin Aver	Funer	al Home/ ethesda,	Bethesda- Maryland	-Chevy 2081	7 Chase, Inc. 4-3501
	Physician	23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications thet caused to one cause on each line	the death. Do no	ot enter the mo	ode of dyl	Ing, such as	cerdiac or	respiratory ar	rest,		Approximate Intervel Between Onset end Death
	/Medical	Immediete Ceuse (Finel disease or condition	. (erclin	Unita	lan	0	000	lut			hours
	Examiner	resulting In death)		Due to (or es e co							1	
	sit sit		b								1	
90,	rificete be executed og physician and as the burial-transit Aedical Examinet	Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or Injury	0	Due to (or es e co	onsequence of	f):						
x 68760,	entificate t ling physic as the t	that initiated events resulting in death) Last	d	ue to (or es e co	onsequence of	r):						
Вох	eth co		U .									
P.O.	at the deeth ce d by the attendi leteched for use Physician/I	Part II. Other significant conditions	contributing to death but	t not resulting in	the underlying	g ceuse gi	iven in Part I.					the cause of death?
	ed by dete	multiple	scle	11201					10	res 20 No	3 Prot	bably 4 ☐ Unknown
Records,	The law requires that the deeth certificate be executed cate has been signed by the attending physician and page 2 should be deteched for use as the burial-transit Completed by Physician/Medical Examin									an eutopsy med?	ava	ere autopsy findings ailable prior to mpletion of ceuse death?
	The law te has sege 2								101	es attino	10	Yes 2□ No
ta	entifica actor, p	25. Was cese referred to medical					26. Place	of Death	(Check only o	ne)		
2	hystel nis ce al direc	examiner?	Hospital:	t 2 ER/Out	patient 3 [DOA Ot	her:	irsing Hor	e 5 Resid	lence 6 DOth	er (Specif	y)
Division of Vital	ath. r: After the funeral	27. Manner of Death 1 Naturel 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day		me of jury M	28c. Inju		2		ow Injury occurr		
Divis	To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page Medical Certification: To Be Com	3 ☐ Sulcide 6 ☐ Could not 8 determined		ry - Al home, fan (Specify)	m, sireel, fecid	ory, office		2	8f. Location (5 City or Tox	Street and Numb n, State)	er or Rura	il Route Number,
	he Hospit in 24 hours he Funer pletely fill edical		hysician: To the best of miner: On the basis of e and manner stat	exemination and								
	withir To the comp	29b. Signature and title of certifier	0 0	0	2	9c. Licen	se number			29d. Dale signe	d (Month,	Dey, Year)
	1	me 2	Mulan	& w)	D19	1294			JUNE	20	, 1999
	T	30. Neme and indress of person who	completed cause of de			SELL	. A	E	GAITH	Mou 26	Not	20879
į	State Registrar	31. Date filed (Month, Day, Year)	32. Pegistrai		9. de	rock	2			1		

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State of Maryland / Department of Health and Mental Hygiene 99

					Cert	ificate o	of Death		Reg. No.		
		1. Decedant's Name (First, Middla	, Last)					2. Data of D	eath		3. Tima of Death
ı	Physicia	ELMER THORNTO	N WALKE	O TTD				JUNE	20 199	Year	1759
į,	/Medica	to English Name // not institution					4b. City. Town	n, or Location of Dea			1/33
	Examine	KENT & QUEEN A					CHESTER		KENT		
L					lant hirthday	If Undar 1 Ya		Hre I o Date of D	latte.	0 Riethole	nas /State or Fami
	Funeral Director	5. Social Security Number 230-52-9500	6. Sex 1 ☑ M 2 ☐ F	7. Aga (In yrs. 57	Yrs.	Months Da		June 2.	lav. Yearl	Virgin	aca (Stata or Forai) 17) 11a
	P .	Usuai Rasidance of Dacadant		10- 0#	Town and an					140	d toolds Oils timb
	Maryler a-f show	Virginia North	ımberland		y,Town orLoc eathsvi					10	d. Inside City Limit
	th with the 23a or 28	Virginia Northu 10e. Street and Number 531 Coan Church	n Road			10f. Zip Coo			United of Amer	States	
020		11. Marital Status 1 Naver Married 2 Marrie 3 Widowed 4 Divorced	Armed Fo	2 No	lf.	as Decedant Yas, specify (☐ Yas 2\(\)	Cuban, Maxican,	n? (Specify Yes or N Puarto Rican, atc.)		e - America ck, Whita, a	tc.
Ö	hou E				16a. Deceda	ent's Usual Oc	cupation		16b. Kind of B	usinass/indu	ustry
21215-0020	within 72 ana. than "na	(Specify only highes Elamantary/Secondary (0-12)	Coilaga (1	-4or 5+)	(Give k lifa. Di Associ	ind of work do O NOT usa ra .ate Vi	ona during most of tired) .ce Presi	id working Ldent	Laborat		Corporati
0	be filed htal Hygie d other event, to				and Ge	neral	Manager 18. Mothar's	Nama (First, Middle	la. Maidan Suman	na)	
Maryland	should be nd Mental marked o	Elmer Thornton		Sr.			Dorot	hy Booth			
	C = 0 -	19a. Informant's Name/Ralationsh Patsy A. Walker						or Rural Routa Num oad, Heatl			
altimore,	8 - 2 0	20a. Mathod of Disposition 1 ☒ Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other (Sp		Stata	Place of Dispos cematary, crams n Bapti	atory or othar	placa)	June 1999	20c Location Heaths Virgin		m, Stata
Balti	permit. Pege Depertment of Important: If any Injury or phose.	21. Signature of Funaral Sarvice L		0690			dress of Facility				137 -
	Physician	23a. Part1. Entar tha disaasa, or shock, or haart failura. List o			h. Do not anta	r tha moda of	dying, such as co				Approximata Intarval Batween Onsat and Death
	/Medical Examiner	Immediata Causa (Final disaasa or condition rasulting in daath)	a CA		C A/2 or as a consequ		THMO	A		3	> Syear
-	יב פי		CO	RONA	RY.	ARTE	ERY D	lsea se			75 year
oʻ	eath certificate be axecuted ettending physician end I for use as the bunel-transit	Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disasas or Injury that initiated avants rasulting in daath) Last	B		or as a consequ						
68760,	icate be physicia s the bu	causa. Entar Underlying Causa (Disaasa or Injury that Initiated avants rasulting in daath) Last	с	Dua to (o	r as a consequ	ance of):					
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Records,	8 50 .	Completed by							as an autopsy formed?	com	ra autopsy findings llable prior to apletion of cause eath?
	The law ata has be paga 2 s							10	Yas 2 No	10	Yas 20 No
Vital	rsician: The	25. Was casa rafarrad to medical axaminar?						of Daath (Chack only	ona)		
of <	5 00	O 1 Yas 2 No	Hospitat: 1 □ I	npatiant 2	ER/Outpatient	300 DOA	Other: 4 Nurs	ing Homa 5 ☐ Ra	sidance 8 □Ott	nar (Specify,)
ion o	After fune			of tnjury th, Day Year)	28b. Tima of tnjury		njuryat Work? 1 □ Yas 2 □ N		e how injury occur	rred	
Division	Hospital or Attence 24 hours after deatl Funeral Director: etaly filled in by the	27. Mannar of Death Naturat 5 Panding invastig 2 Accidant invastig 3 Suicida 6 Could n 4 Homicida datarmi	ned 20a. Place	of Injury - At he ng, atc. (Specif	oma, farm, stra	at, factory, off	ice		(Street and Numi own, Stata)	ber or Rural	Routa Number,
	Hospital 24 hours Funeral letaly filled	29a. Cartifier 12 Certifying	xaminer: On tha ba					place, and dua to the			

20

30. Nama and addrass of parson who complated causa of death (Itam 23a) (Type, Print) Helen Noble, M.D. 100 Brown Street, Chestertown, Maryland

State Registrar

31. Data filed (Month, Day, Year)
JUN 23 1999

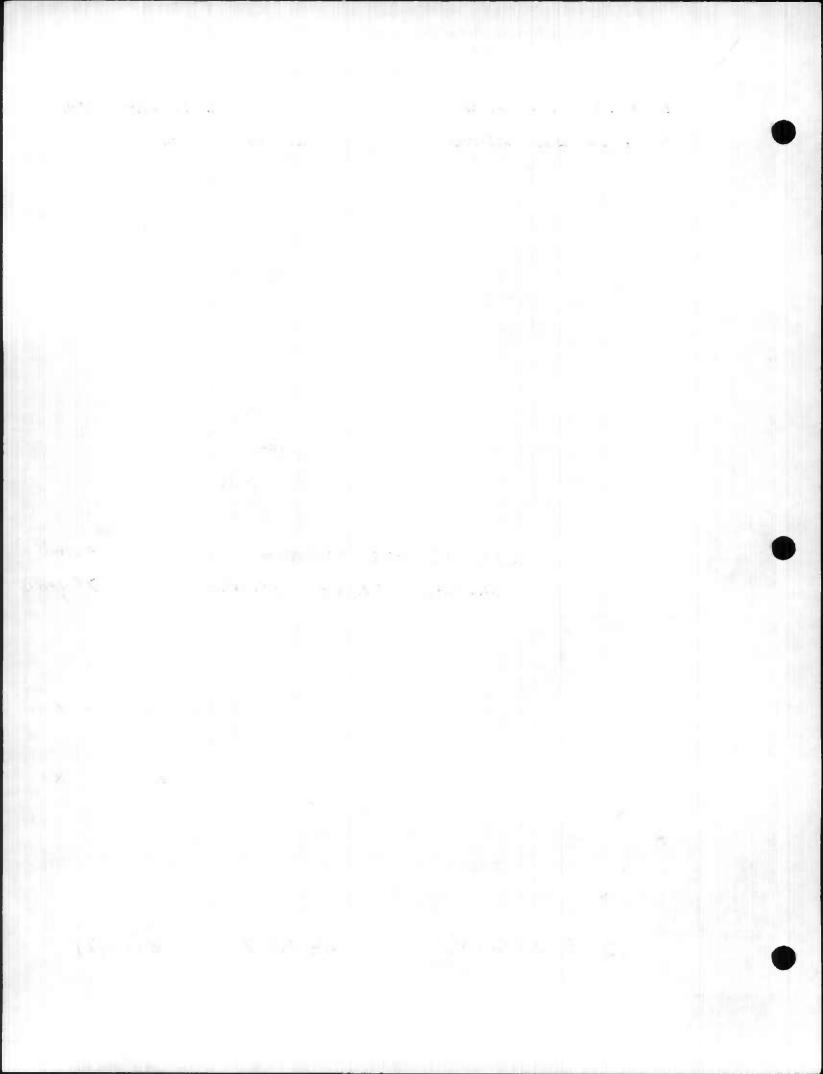
29b. Signatura and titla of certifiar

32. Registrar's Signatura

29c. Licansa number

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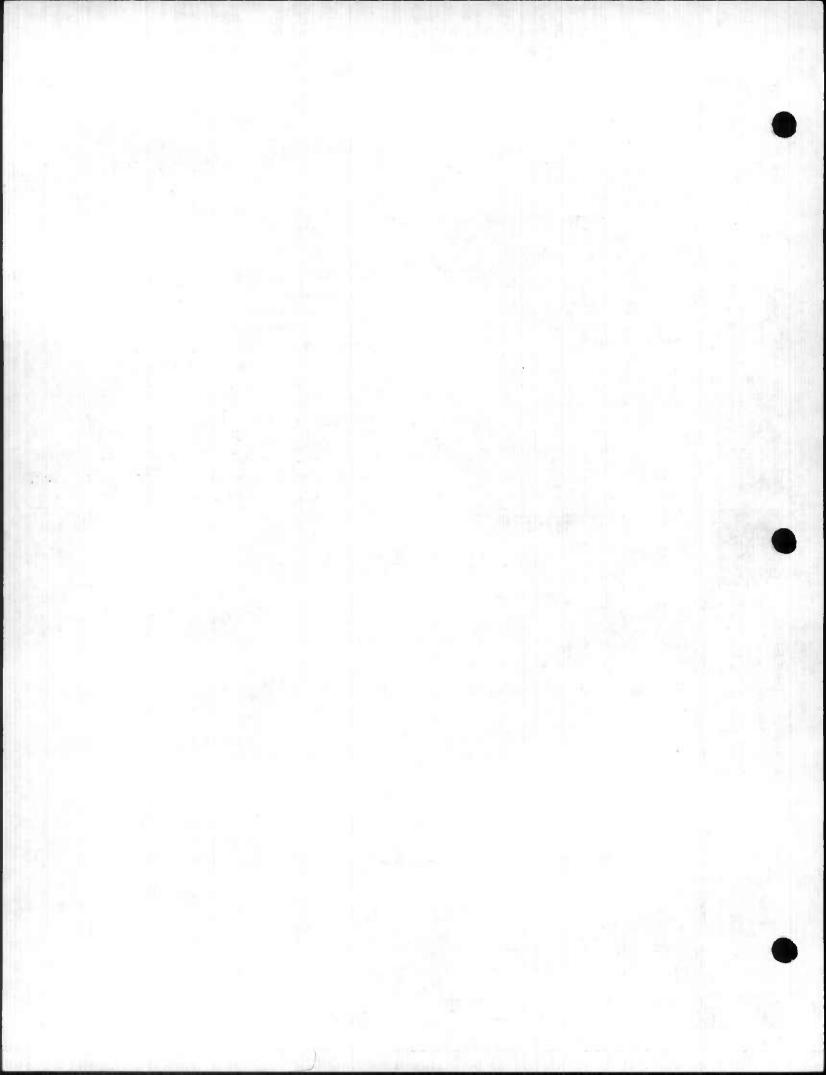
29d. Date signed (Month, Day, Year)



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State of Maryland / Department of Health and Mental Hygiene 9 9 2 | 6 4 |

				Certifica	te of	Death		Reg. No.		
	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Dey Year 3. Time of De		
sician edical	ALBERT GEORGE WELLENS							9, 1999	8:25 P	
miner	4a Facility Name (If not institution, give street end number)					4b. City, Town, or L			f Death	
	7804 HACKAMORE DRIVE					POTOMAC		MONTGOMERY		
ral or	5. Social Security Number 579-40-4986	4₩ 4 0□ E		rs. If Under	Deys	If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, De DEC •	th Year) 16,1911	9. Birthplace (Stete or For Country) PENNSYLVANI	
	Usual Residence of Decedent		T40. 0h. T-							
al Director	MD MONTGO	400						10d. Inside City Lin		
ě	10e. Street and Number			10f. Z	ip Code			10g. Citizen of Wi	nat Country?	
9	7804 HACKAMORE DRIVE			20854				UNITED STATES		
by Fune	11. Marital Status 1 Never Merried 2 Merrier 3 XWidowed 4 Divorced			13. Wes Deci If Yes, sp 1 Yes		dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	14. Race Bleck Specify:	- American Indian, , White, etc.	
5	15. Decedent's	Education	16a.	Decedent's Usi	uel Occup	oation	ino	16b. Kind of Bus	iness/Industry	
Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4		5+)	(Give kind of work done during most of working life. DO NOT use retired) ATTORNEY			ung	LEGAL		
ŭ	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Mick			e (First, Middle	ldle, Maiden Sumeme)		
80						MARY	PREUSS			
5					Address (Street and Number or Rural Route Number, City or Town, State, 2			itate Zin Code)		
	MARY SUE WELLEN			210 BAN	-			RTH CAROL		
	20a. Method of Disposition	D IAION DAG					Dete		City or Town, State	
pnés. To Be C	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON NAT L. CEMETERY 7/9/99 ARLINGTON						ON, VIRGINIA			
once	21. Signature of Funeral Service Licensee 22. Name end Address of Fecility HINES-RINALDI FUNERAL HOME, 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD									
an	23a. Part1. Enter the distance, or complications thel caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line.						Approximete Interval Between Onset and Deet			
al	Immediate Cause (Final disease or condition METASTATIC MELANOMA							2 YEARS		
er	resulting in death) Due to (or es a consequence of):									
le L	33-46-									
edical Examiner										
-										
Physician		d								
9	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert					ven in Pert I.	23b. Did tobacco use contribute to the cause of dea			
=	PROSTATE CANCER				10					
by P	PROSTATE CANCE	R					10	Yes 2000	3 Probably 4 Unk	
Ď	PROSTATE CANCE	R					24a. Wes	Yes 2000 an autopsy primed?	24b. Were autopsy findir aveilable prior to completion of cause of death?	
b	PROSTATE CANCE	R					24a. Wes	an autopsy	24b. Were autopsy findir available prior to	
eted by	25. Was case referred to medical	R				26. Place of Dee	24a. Wes	an autopsy ormed? Yes 2∏ No	24b. Were autopsy findir aveilable prior to completion of cause of death?	
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leted by	25. Was case referred to medical examiner? 1 Yes	Hospitel: 1 Inpati 28a. Date of Inj (Month, De	ury - At home, fer c. (Specify)	m, street, fector	28c. Inju Wo 1 ry, office	ner: 4 Nursing H	24s. Wes perfit the (Check only one 5 12 Res 28d. Describe 28f. Location City or You end due to the	Yes 2 1 No one) idence 6 □Other how injury occurre win, Stete)	24b. Were autopsy findir aveilable prior to completion of cause of death? 1 Yes 2 No r (Specify) d r or Rural Route Number,	
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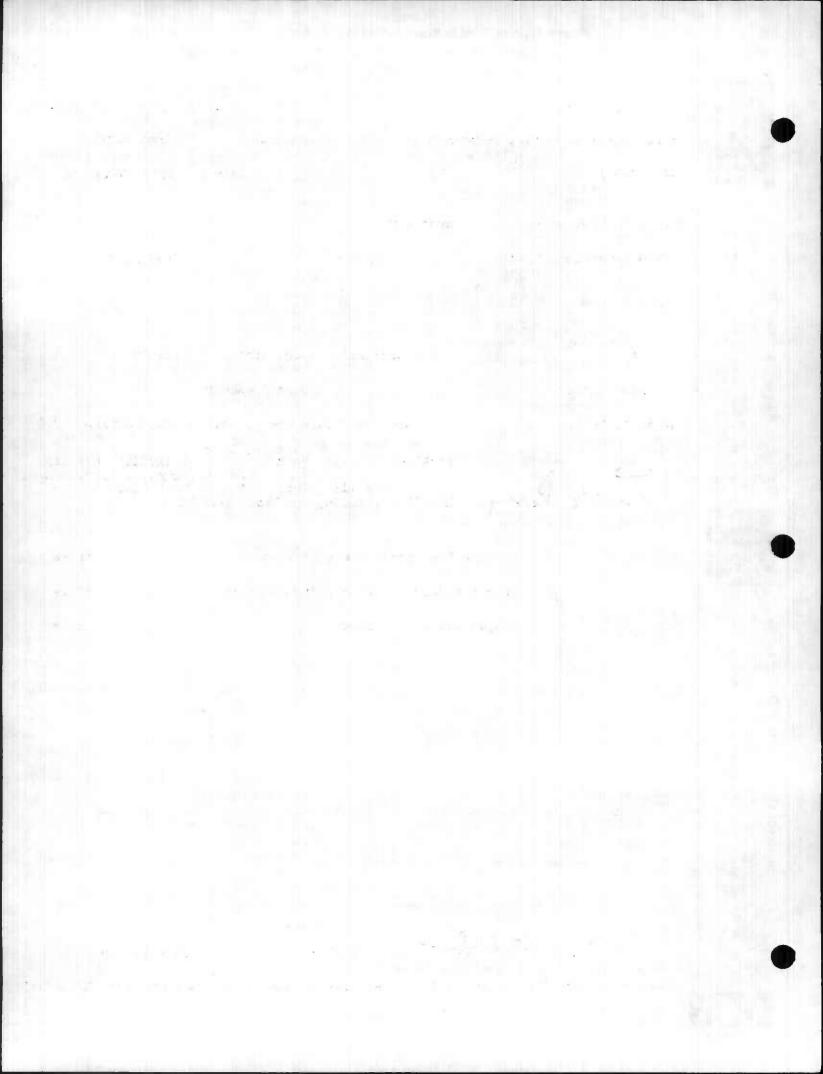
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Deeth **Physician** June 21, 1999 5:30 AM Mary E. Wilson /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Shady Grove Adventist Nursing Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (in yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthpiece (State or Foreign Country) **Funeral** Deys 1□ M 2\ F Yrs. 79 July 12, 1919 Director 578-38-3476 Virginia Usual Residence of Decedent with the Maryland Show 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shore the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Germantown 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 12700 Foundstone Road 20876 death Funeral United States Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11 Maritel Status filed within 72 hours after 1 Never Merried 2 Married ☐ Yes 2 X No Yes, Give altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: p 3 Widowed 4 □ Divorced Yeer or Detes: White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12 Communication Specialist U.S. Government permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, I 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Douglas Barker Zona Prescott 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Linda A. Bell/Niece 23104 Bank Barn Court, Germantown, Maryland 20b. Plece of Disposition (Name of cametery, crametory or other place) June 24, 1999 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, Maryland 21. Signatur The Fineral Service Lice see 22. Name end Address of Fecility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue M00803 Rockville, Maryland 20850-2805 121 23e. Pert1. Enter the disease, or complications that deused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Final Chronic Obstructive Lung Disease diseese or condition resulting in deeth) Years Examiner Due to (or es e consequence ot): Examiner Lung Carcinoma with Left Pneumonectomy Years the death certificate be executed physician and s the burial-trans Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Last Due to (or es e consequence of): Congestive Heart Failure Years Physician/Medical Due to (or es e consequence of) 88 USB signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 0 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy Completed peen completion of cause of death? page 2 s 1 Yes 2 No 1 ☐ Yes 2 No certificate Division of Vital Attending Physician: director. 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 28e. Dete of Injury (Month, Dey Year) funeral 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? After 1 Naturel 5 Pending after death. 1 Yes 2 No 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, olfice building, etc. (Specify) 4 Homicide ò 24 hours a Hospital 1 🖄 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier pletely (Check only one) 2 Medical Examiner: On the basis of examinetion end/or Investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner steted. To the Vithin 2 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D31391 June 21, 1999 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Subhair H. Abdulfarg, M.D. 481 N. Frederick Avenue, #230, Gaithersburg, MD 20879 31. Dete filed (Month, Day, Year) Registrer's Signeture

State Registrar

JUN 23 1999

DHMH 16 Rev 6/95



Amend #5,6/29/99, BMW, Montg. Co

1. Dacedant's Name (First, Middle, Last)

2. Data of Death

17904 Georgia Ave., Suite 304, Olney, MD 20832 301-924-2790

3. Tima of Death

30. Name and addrass of person who completed causa of death (Itam 23a) (Type, Print)

32. Ragistrar's Signature

Thomas E Dooley, MD.

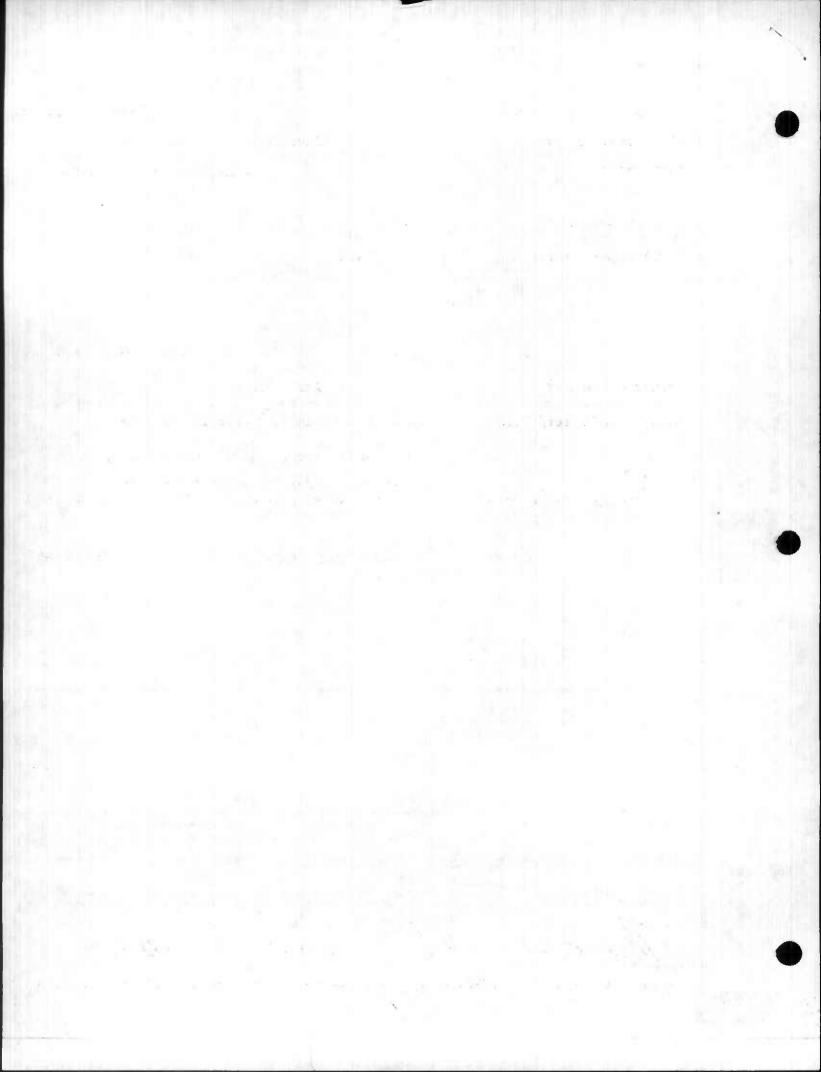
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31. Data filed (Month, Dey, Year)

DHMH 16 Ray 6/95

State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Deeth 3. Time of Death 1. Decedent's Nema (First, Middle, Last) **Physician** Mildred A. Wykoff 23, 1999 June 17:30 /Medical 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, giva street and number) 4c. County of Death **Examiner** Montgomery General Hospital Montgomery Olney If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpiece (State or Foreign Country) **Funeral** Deys 1 □ M 2 🖸 F Months Hours Min 74 Yrs. 285-22-5717 **Director** Sept. 9, 1924 Kentucky Usuai Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumstic event, the Medical Examinar must be notified at 1 ☐ Yas 21 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zlp Code 10g. Citizen of Whet Country? with 3311 S. Leisure World Blvd., #3D permit. Pages 1 and 2 should be filed within 72 hours aftar death 1 Department of Haalth and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a and injury or other traumatic event, the Medical Examiner must enter 20906 United States Funeral 12. Wes Decedent Ever in U,S Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yas 2 ☒ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2N No Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Teacher 5+ Public Schools 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Volney Nickell Lillie Ward 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) 19e. informent's Name/Reletionship (Type, Print) Ruby Hill/Sister 14558 Kelmscot Drive, Silver Spring, Maryland 20906 20b. Plece of Disposition (Name of cemetary, cremetory or other plece) June 28, 1999 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State New Point, Indiana 4 ☐ Donetion 5 ☐ Other (Specify) Rossburg Cemetery 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, M01126 Rockville, Maryland 20850-2805 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, but cally one cause on each line. Approximete intervel Between Onset and Death **Physician** /Medical immediate Cause (Final disease or condition resulting in death) HEMORRHAGE INTRACEREBRAL days Examiner Due to (or es e consequence of) Examiner physician and the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of): certificata be exec Box 68760, Physician/Medical thet initieted events resulting in deeth) Lest Due to (or es a consequence of): as esn ŏ ed by the a Pert tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributa to the cause of death? Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to 24a. Wes en eutopsy Completed completion of cause of deeth? page 2 has 1 ☐ Yes 2 ☐ No 1 Yes 22 No certificata Division of Vital Attending Physician: 25. Wes case referred to medical axaminar? Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 □ ER/Outpetient 3 □ DOA this 28e. Dete of injury (Month, Dey Year) funeral 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Affer 1 Neturei 5 Pending Investigation death. 1 Tes 2 No 2 Accident 24 hours after deal Funeral Director: 6 Could not be determined 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 3 ☐ Suicida Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide ò Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and due to the cause(s) and manner stated.

| Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number JUNE 24, 1999 1 30. Neme end eddress of person who completed cause of deeth (item 23a) (Type, Print) OLNEY MD 20832 201

State Registrar 31. Dete filed (Month, Dey, Year)

HOWARD

JUN 25

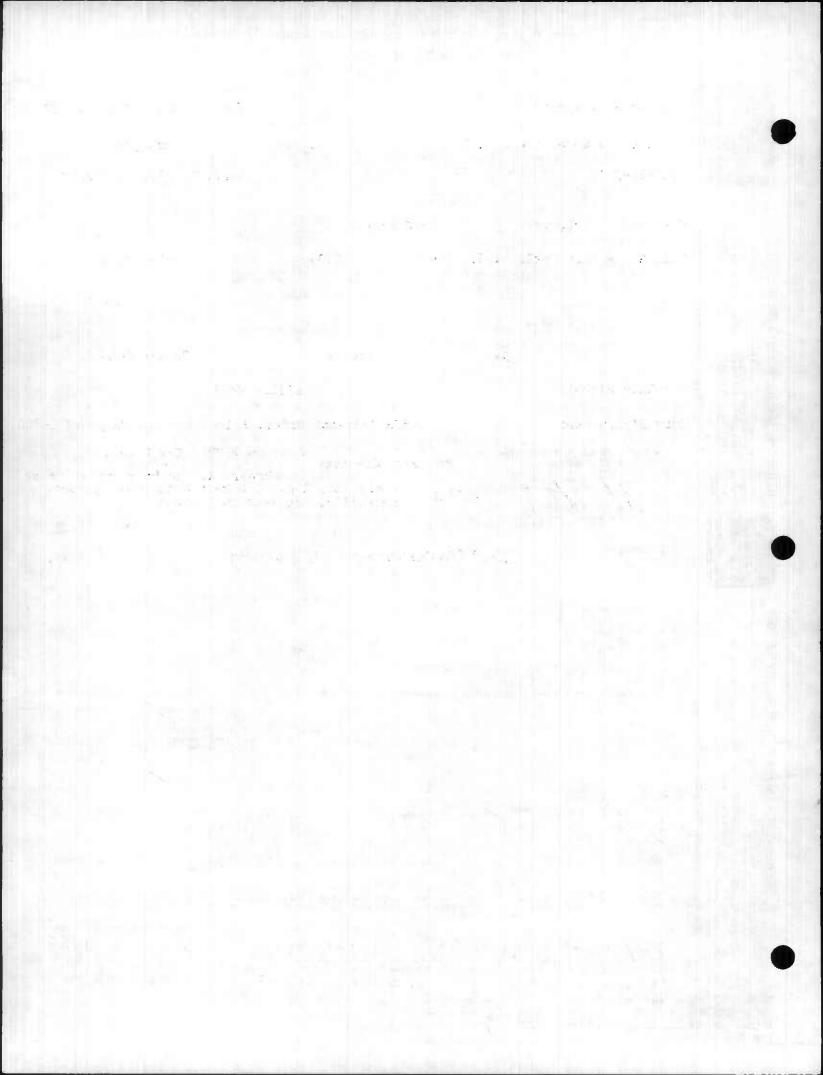
D. CHAZIN



MD

3416

OLANDWOOD CT.



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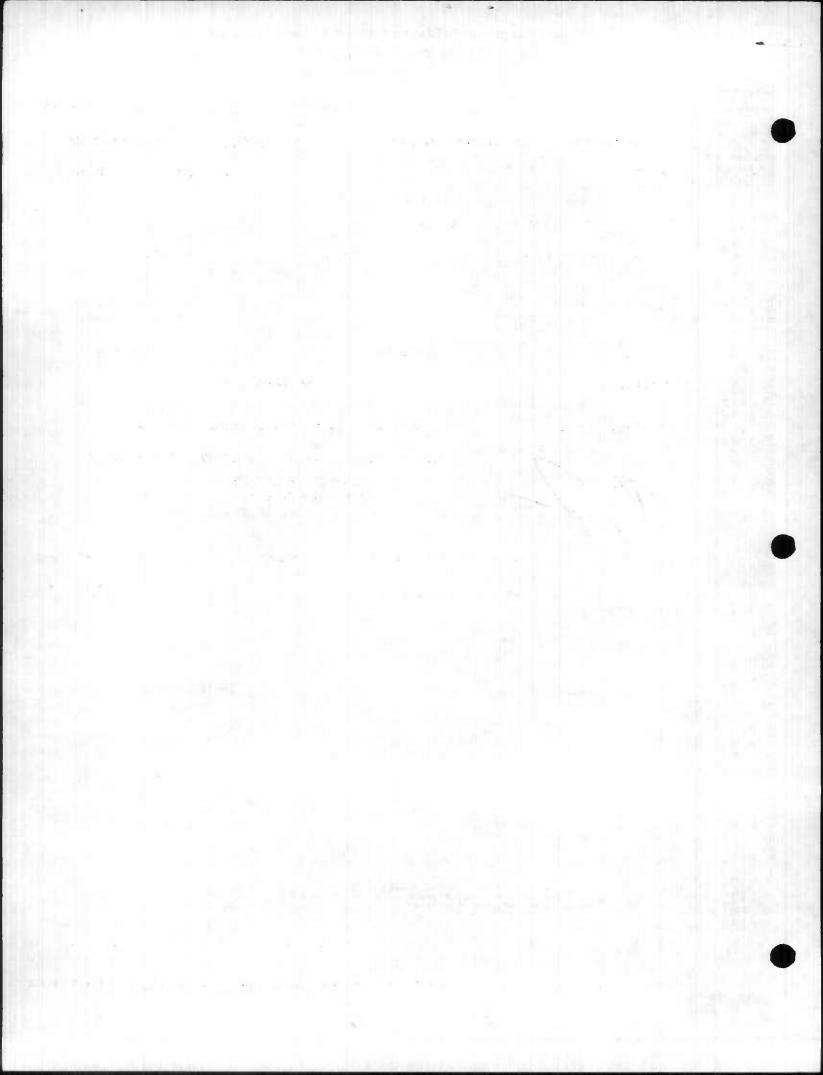
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Physi		Odazzoa	Isabell	Marniak						June 2	Day 23. 1999	Yeer	2:30) DM
/Med Exam				ra street and number	r)				4b. City, Town,	or Location of Dea		of Death		J_PM_
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permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mental hygiena. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at	by	1 Navar Marr 3 Widowed	ied 2⅓ Married 4 ☐ Divorced	1 ☐ Yas 2 ☐ If Yas, Give Year or Datas					Specify:			y: Whi	te	
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d within 72 hours eff gjene. rr then "neturel", or . the Medical Exam	nple	Elementary/Seco		College (1-4o	r 5+)	life			during most of d)	violiting.				
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_ 0 _ 0	Med							29c. License number 29d. Data signed (Month, Dey,			Dev. Year)			
at tip	-	250. Signatura ent	Alla	XX1/1	211	- 1	P							
To the To the compl		30. Nama and address of person who completed ceusa of daath (Item 23e) (Type, Print)						D25759 June 23, 1999						
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negicai aminer	4a Facility Name (If not Institution, giva	street and number)		1	lb. City, Town, or L		h 4c. County	of Deeth	
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eral ctor	5. Sociel Security Number 214-17-1020 Usuel Residence of Decedent	7. Aga (In yrs.	Yrs. Mor		Hours Min.	8. Date of Bir (Month, De 10-10-	y, Year) -22	Country)	e (Stete or Foreig na
	10a. Stete 10b. County	10c. Cit	y, Town or Location)					Inside City Limit
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eted	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a. Decedent's	Usuel Occup	ation duning most of work	kina	16b. Kind of Bu	siness/Indus	try
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To	19a. Informent's Neme/Reletionship (T	ype, Print)	19b. Meiling Add	dress (Street	end Number or Ru	ral Route Numb	per, City or Town,	State, Zip Co	ode)
y other t	Zhen Yang (son) 20e. Method of Disposition	20b. F			ve Dr. Po	tomac,	1D 20854 20c. Location -	City or Town	Stete
any injury or o	1X Buriel 2 Cremetion 3 4 Donetion 5 Other (Specific	Hemovel from Stete	Piece of Disposition cometery, crematory ir fax Memo			-22-99		ax, VA	
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edical (reicien: To the best of my kno iner: On the basis of examine end menner eteted.							
×	29b. Signeture and title of cartifier			29c. Licens	e number		29d. Date signe	d (Month, De	y, Year)
	POSCON ABAIL	1 ~ D		723	317		JUNE	18 19	599
	30. Neme end address of person who c	completed cause of deeth (Item	n 23e) (Type, Print)				1.1		
	JOSEPH ABALL	16220 4	ederick	KOAD	Suite 2	17 GAL	theysbur	c MD	70877

DHMH 16 Rav 6/95



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Committee the second

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State of Maryland / Department of Health and Mental Hygiene 99 2 1 6 4 8

AMEND ITEM #	5 PER F.H. G773 7-8-99 WR. Certificate of Death Reg. No.
Physician	1. Decedent's Name (First, Middle, Last) BETTY L. ZINZ 2. Date of Death Month JUNE 21, 1999 2:45 PM
* /Medical Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY
Funeral Director	S. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Nov. 21, 1925 LEESBURG, VA
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLANI) PRINCE GEORGES HYATTSVILLE 10d. Inside City Limits WATTSVILLE 10d. Inside City Limits
ith with the Marylar 23a or 28a-f show ust be notified at ral Director	10e. Street and Number 2110 HANNON STREET 10f. Zip Code 20783 10g. Citizen of What Country? UNITED STATES
ar dea	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Warried 3 North Wes, Green or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes, Specify: WHITE
Ind 21215-002 be filed within 72 hours lat Hygiene. d other than "natural", event, the Medical Ex-	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 TH 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BAR-TENDER 16b. Kind of Business/Industry PRIVATE
Maryland 21215-0020 d 2 should be filed within 72 hours aft int and Mariel Hygiene. 7 Is marked other than "natural", or traumatic event, the Madical Evant To Be Completed by F	12TH BAR-TENDER PRIVATE 17. Father's Neme (First, Middle, Last) WILLIAM R. GRIMES BAR-TENDER 18. Mother's Name (First, Middle, Maiden Surname) LUCY DROTT
	19a. Informant's Name/Relationship (Type, Print) LINDA DOOLEY/DAUGHTER 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) BOX 34011, BALTIMORE, MARYLAND 21221
Baltimore, semit. Pages 1 ar Department of Hea mportant: If them any injury or other page.	20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetary, cremetory or other place) UNION CEMETERY 20c. Location - City or Town, State LEESBURG, VIRGINIA
Balt permit. Departiment importing eny inj	21. Signature of Europh Service Lice see 22. Name and Address of Facility DUDLEY FUNERAL HOME 3200 RHODE ISLAND AVE., MT. RAINIER, MD 2071
Physician /Medical Examiner	Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequence of):
Box 68760, nath certificate be executed attending physician and for use as the burial-transit clan/Medical Examiner	Sequentially list conditions, if eny, leading to immediate ceusa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): c
P.O. nat the de d by the latached Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 10 COCONGO A 6+65 D SCOSC 10 Probably 4 Unknown
of Vital Records, Physician: The law requires that this certificate has been signed rail director, page 2 should be determed director, page 2 should be determed to the complete of the complete of the complete of the cert	O Choonic Obstantiviting Disable 24a. Was en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
Vital Re- ician: The lav certificate has rector, page 2 Be Comp	25. Was cese reterred to medical 26. Plece of Death (Check only one)
After fune	exeminer? 1
Divisic To the Hospital or Attend within 24 hours after docu- tro the Funeral Directors: completely filled in by the Medical Certificat	29a. Certifler (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
To the H within 24 To the F complete	29b. Signature and title of certifier Market M. D. D. 24593 29d. Date signed (Month, Dey, Year) Cone) 29b. Signature and title of certifier Market M. D. D. 24593 Cone) 29d. Date signed (Month, Dey, Year) Cone)
(12)	30. Name and address of person who completed cause of deeth (Item, 23a) (Type, Print) D. 3331 - TOLEDOTERRACE MOHAM MED WATTSVILLE, MD. 2078:
State Registrar	31. Dete tiled (Month, Day, Year) JUN 2 4 1999 2. Registrar's Signature

Physician /Medical Examiner 68760 death certificate be

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

Funeral

Director

Ahow

then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

the Maryland

death

filed within 72 hours after

Hyglene.

permit. Peges 1 and 2 should be file.
Department of Heelth and Mental Hyg.
Important: If Nem 27 is marked other
any Injury or other traumestangles.

21215-0020

Baltimore, Maryland

Box

P.O.

Records,

Division of Vital

The law requires

Physician:

or Attending

Hospital

To the Hosp within 24 ho. To the Fune completely fi

Examin physician and the burial-transit Physician/Medical 188 by the signed by I by Completed page 2 has 8 To this Certification: After s after death.
If Director: Aft
ad in by the fur filled in t 24 hours

Pert II. Other algniftcant conditions contributing to death but not resulting in the underlying cause given in Part I. Diverticulitis, Status Post Colostomy, Memory Loss 25. Wes case referred to medical examinar? 1 Yas 2X No 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

edical

31. Dete filed (Month, Day, Year)

JUL 0 9 1999

Susan J. Miller, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

5

6844 Tulip Hill Terrace, Bethesda Maryland 20816 oouts

1999

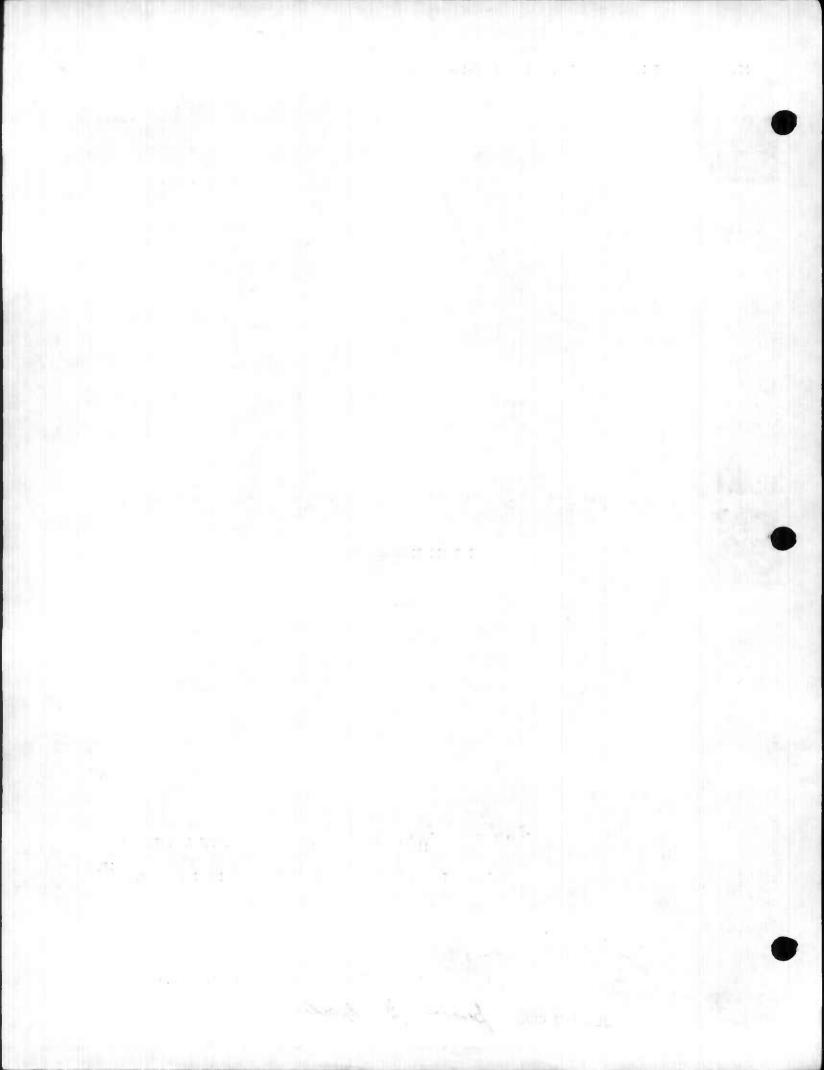
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July

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ysician	AMS 23 PART I, 27, 28A- 1. Decedent's Name (First, Mic Richard	idle, Last)	Adams					2	P. Data of Deat Month JULY	Day	Year	3. Time of Death
Medical aminer	4e Facility Neme (If not Institute 6606 SUITL)						ib. City, Ton		tion of Death	5, 1999 4c. County PRINC		11:31 PM ORGES
eral ctor	5. Social Security Number 175–30–1892	6. Sex 1 □ M 2 □ F	7. Age (In yrs.	last birthday) 62 Yrs.	If Under Months	1 Year Days	If Under a	Min.	Date of Birth (Month, Day, CT. 15	Year) 1936	9. Birthpla Countr Penr	ce (State or Foreign y) nsylvania
Wester	Usual Residence of Decedent 10a. State 10b. Cour MD Po	rince Geor		ty, Town or Lo Morning							100	d. fnside City Limits 1 ☐ Yes 2 ☑ No
for must be notified at	10e. Street and Number 6606 Suitland	d Road			10f. Zip	Code 207	746		10	0g. Citizen of V US		y?
by	11. Marital Status 1 Never Married 2 M M 3 Widowed 4 Divorce	arried 1 X Ye	ecedent Evar in U Forces? s 2 No Give Dates:		Was Deced if Yes, spec 1 Yes 2			gin? (Speci , Puerto Ri	fy Yes or No- can, atc.)		e - America k, White, et	
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other traumatic	19e. Informent's Neme/Rejetic Barbara Bunti			952 C	heste	er Ri	iver [ille, N		2009) 21638
8	20a. Method of Disposition 1 Buriai 2 Cramatio 4 Donetion 5 Other		m State	Piece of Dispo cematery, crem Jnionto				7/:	10/ ₉₉	Cherry		
eny injury	21. Signature of Funeral Servi	se Licensee	evr)							e @ Mead idge, M		ge MP, Inc. 1075
ian ical iner	23a. Part1. Enter the diseese, shock, or heert feliure. L' Immediete Cause (Finel disease or condition resulting in death)		DRUG INTOX		w.	e of dyin	g, such as	cardiac or I	respiratory erre	est,		Approximate nterval Between Onset and Death
e burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Disease or injury	5 b	Due to (Due to (or es e consequence of):								
77 60	that initiated events resulting in death) Last	1	Due to (d	or es e conseq	uence of):							
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DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 05 Yeer 99 SEnora Baytop 07 10:42 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Union Memorial Hospital Baltimore 7. Age (In yrs. last birthdey) 52 Yrs. If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number 9. Birthplace (State or Foreign Country)
MD Days Hours 1 □ M 2 🔀 F 219-52-3989 Usual Residence of Decedent 10e. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits 1X Yes 2 No NA Baltimore 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 627 McKewin Avenue 21218 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 24 ☐ No if Yes, Give Year or Dates: 1 ☐ Yes 2 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) NA Homemaker in & out of home 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Sumema) Paul Α. Baytop Camilla I. Dutton 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21218 19a. Informant's Name/Relationship (Type, Print) Lolita Davis 627 McKewin Avenue Baltimore, Maryland 20b. Place of Disposition (Neme of cemetary, cramatory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State Voshell Mem. Gardens 08-10-99 4 ☐ Donetion 5 ☐ Othar (Specify) Dundalk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death immediate Causa (Final disease or condition resulting in death) Arrhythmia Dua to (or as a consequenca of): Hypenthermia Sequentielly list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequenca of): Diabetes Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part f. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Ware autopsy findings available prior to 24a. Was en autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 25. Was casa referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 inpatiant 2 ER/Outpatlent 3 DOA 27. Manner of Death 28a. Date of injury (Month, Dey Year) 28b. Tima of 28c. injury at Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No invastigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28a. Placa of Injury - At home, farm, streat, factory, offica building, etc. (Specify) 28f. Location (Straat and Number or Rurel Route Number, City or Town, Stata) 4 - Homicida

The law requires that the death certificate be executed physician and s the burial-trans P.O. Box 68760. 5 signed b Division of Vital Records, peed ate has certificate Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certificately filled in by the funeral director,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

6

Items 23a

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinations.

Physician /Medical

Examine

Examiner

Physician/Medical

Baltimore, Maryland 21215-0020

MD

Director

Funeral

by

Completed

traumatic event, the Medical Examiner must be notified at

the Maryland

ð Completed Be Certification: To To the Hospital or within 24 hours eff To the Funeral Di completely filled in Medical

29a. Cartifian

29b. Signature and the of certifier

de

State Registrar

Paul B. Kan UMH E.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

D0053373 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. Licanse number

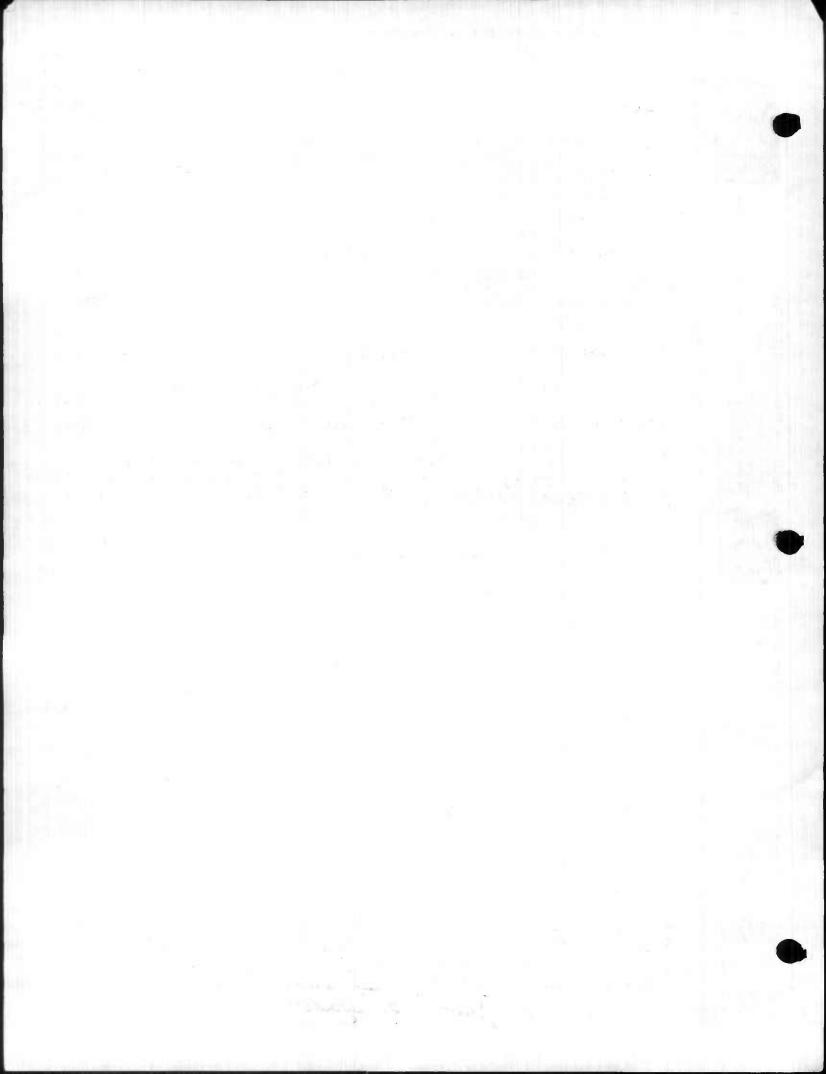
29d. Date signed (Month, Day, Year)

201 E. University Farkway

Boltimore IMP 31315

Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and mannar as stated.

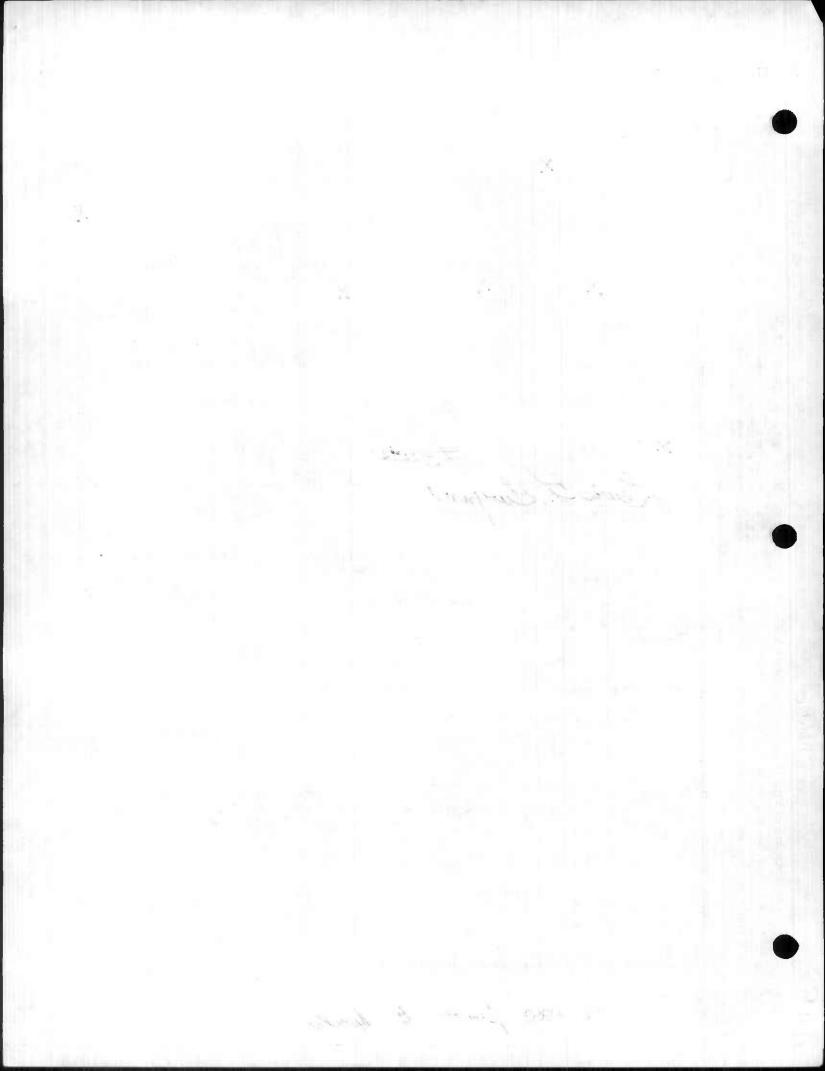
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mennar stated.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

AMENDITEM	: #20B,	PER F.H. G7		NR.	ivial ylan		rtificate		Death		Reg. No.	9 2	1652
	hysician	1. Decedent's Name	MES THO		TLER					2. Date of E Month	Day	Year	3. Tima of Death 0935 AM
	/Medical Examiner	4s Facility Name (h 4167 FA	not institution, give		ber)				4b. City, Town, or U		th 4c. Count	-	
	ineral rector	, , , ,	711	ex M 2□ F	. Age (In yrs. 64	last birthday Yrs.	Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth (1936	9. Birthpi Coun Sout	ace (State or Foreign h Caroli
puejÁi	No.	Usual Residence of 10a. State	10b. County			y, Town or L						10	Od. Inside City Limits
the Ma	28a-f ahon notified at rector	MD . 10e. Street and Nun	N/A		В	ALTIM	IORE 10f. Zip	Codo			10g. Citizen of	What Cour	1 Yes 2 No
5	23a or rai Dir	4167 FA		AVENUE				216			U.S.		
1	by Fune	11. Marital Status 1 Never Marri 3 Widowed	ed 2 Merried	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Del	lent Ever in U	S. 13.	Wes Deced If Yes, spec		lispanic Origin? (S _I an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	lo- 14. Ra Ble Specif	ce - America ck, White, o	
15-0 72 ho	netural.	(Spec	15. Decedent's Edify only highest gra	lucation de completed)		16a. Dece	dent's Usua kind of wor DO NOT us	l Occup	petion during most of work	king	16b. Kind of B	lusiness/Ind	lustry
212 d within	other than "naturn event, the Medical Be Completed	Elementary/Secon UNKNOWN		College (1- JNKNOWN			DE H				MACHIN	E PA	RTS
be fied 2	o vent.	17. Father's Name (18. Mother's Nam			ne)	
Bryle Bhould	To To	NATHANI I		1PLER		19b. Meil	ing Address	(Street	SARAH and Number or Ru			, State, Zip	Code)
, Marylan and 2 should be	or trau	MARGIE 1		(WIFE)		4167	FAI	RVI	EW AVEN		ALTIMOR		
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene.	important: if item 27 is marked other than any injury or other traumatic event, the language. To Be Compi	20a. Method of Disp 1 Aurial 2 [4 Donation	osition Cremetion 3 Other (Specify	Removel from S	7	200	at W	OOD	7/7/99 LAWN CE	Date METER!	20c. Location BALTI		wn, Stete MARYLA
Balt. Depart	any in	21. Signature of	Prai Service Licen Wes J.	Ju ENI	S T.	GWYNÎ	1,1	MID	PARK HE				21215-63 O.,MD.
68760, Mate be assouted	ing physician and see as the buriel-transit Medical Examiner	disease or condition resulting in death) Sequentially list cor if any, leading to imcause. Enter Under Cause (Disease or that initieted events resulting in death) L	nditions, mediate nying njury	b	Due to (o	e Arte or as a conse or es e conse or as a conse	quence of):	lero	otic Card	Lovascu	lar Dise	ease	
Box	for use a	Dat II Other steeld			Ab b. 4 1	daine in other			no in Donal	l age pu	d takanna una ar		the cause of death
P.O. That the	igned by the extending be deteched for use a by Physician/M	Part II. Other signifi	cant conditions co	ontributing to dea	in but not res	uiting in the t	indenying ca	iuse gr	ven in Part I.	-	Yes 2 No		ebly 4 XX nknow
	should									per	s en eutopsy formed? ECTION	COI	ore autopsy findings bilable prior to appletion of cause death?
al B	director, page 2	OF 141									Yes XX No	10	Yes 2□ No
yalola		25. Was case referrexaminer? XXYes 2□		Hospitel: 1 In	patient 2	ER/Outpatie	nt 3 DO	A Oti	26. Place of Dea her: 4 Nursing H		rone) sidence 8 □Ot	her (Specif)
Vision of Vita	funera funera tion:	27. Manner of Death XX Natural 2 Accident	5 Pending investigation		Injury , Day Year)	28b. Time o Injury	of M	Bc. Inju Wo 1	ryet rk?]Yes 2∐No		how injury occu		
DIVISIO	ed in by the	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	200. Place 0	of Injury - At he g, etc. (Specif	ome, ferm, st	reet, fectory	, office			(Street and Num own, State)	ber or Rura	l Route Number,
To the Hospital within 24 hours	completely filled Medical Ce	29a. Certifier (Check only one)			is of examina				me, date and place opinion, death occur				
To the	ocup We	29b. Signature and	emir L	Chut	w				c.M.E.		29d. Date signe JULY		
		30. Name and address Dennis (chute M.D	completed cause	of death (Item	23a) (Type L Penn	Stree	et,	Baltimore	e, Mary	land 212	201	
P R	State legistrar	31. Date filed (Monti			gistrar's Signa			,					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Neme (First, Middla, Last) Day Month **Physician** David Franklin Berry 1:54pm 4b. City, Town, or Location of Death 4c. County of Death /Medical 4a Facility Name (If not institution, giva street and number) Examiner 7910 West End Drive Orchard Beach Anne Arundel If Under 24 Hrs. 5. Sociel Security Number 6 Sax 7. Aga (In vrs. last birthday) If Under 1 Yaer Birthplece (Stete or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Deys Hours 1₽M 2□F Months 214-44-3227 Director 5, 1947 West Virginia Usuai Rasidence of Decedant 10a Stata 10b. County 10c. City, Town or Location show 10d. Inside City Limits Anne Arundel Orchard Beach 1 ☐ Yas 2 No Director 288-f 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 7910 West End Drive 21226 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) "natural", or items 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 🖸 No 14. Rece - American Indian, Black, Whita, atc. 72 hours after 1 Never Merried 2 Merried 1 Yas 2 No Specify: P 3 Widowed 4 Divorced White Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Tractor Elementary/Secondary (0-12) Collega (1-4or 5+) permit. Pages 1 and 2 should be filed wit. Department of Health and Mentel hygiene Important: If tem 27 is marked other tha any fulury or other treumatic event, tha 1 phose. Truck Driver Trailer Transfer 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be David Crockett Berry Lucille Smith 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsa F. Berry/wife 7910 West End Dr. Orchard Beach, MD 21226 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata Date 1 ☐ Burial 2 【Cramation 3 ☐ Removal from Stata Metro Crematory, Inc. 5 Othar (Specify) 07/08/99 4 Donation Baltimore, MD 22 Name and Address of Facility of Maryland, Inc. 21. Signature of Funeral Service Licers Cremation Society of Marylar 299 Frederick Rd. Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. 299 Frederick Rd. Baltimore, MD 21228 Approximate Interval Between Onset and Deeth **Physician** /Medical tmmediata Cause (Finel 2 Month diseasa or condition rasulting in death) Examiner Dua to (or as a consequence of) Examine ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): the 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. signed by the 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings evailable prior to Completed 24a. Was an autopsy performed? completion of cause of death? 200 No 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: 25. Was casa rafarred to medicat examiner? Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Menner of Death 28d. Describe how injury occurred 28h Time of 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? Affer 1 Netural 2 Accident 5 Panding death. 1 ☐ Yas 2 ☐ No investigation efter deatl 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of tnjury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours effer To the Funeral Dire completely filled in b 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Cartifiar

State DHMH 16 Rev 6/95

altimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

Division of Vital

Registrar

29b. Signature and titla of certifier

31. Date filed (Month, Day, Year)

udhisht

array M.D

30. Nama and address of person who complated causa of death (Item 23a) (Type, Print)

Markon

32. Registrer si Signatura

1600 Crain

29c. License number

D39505

29d. Data signed (Month, Day, Year)

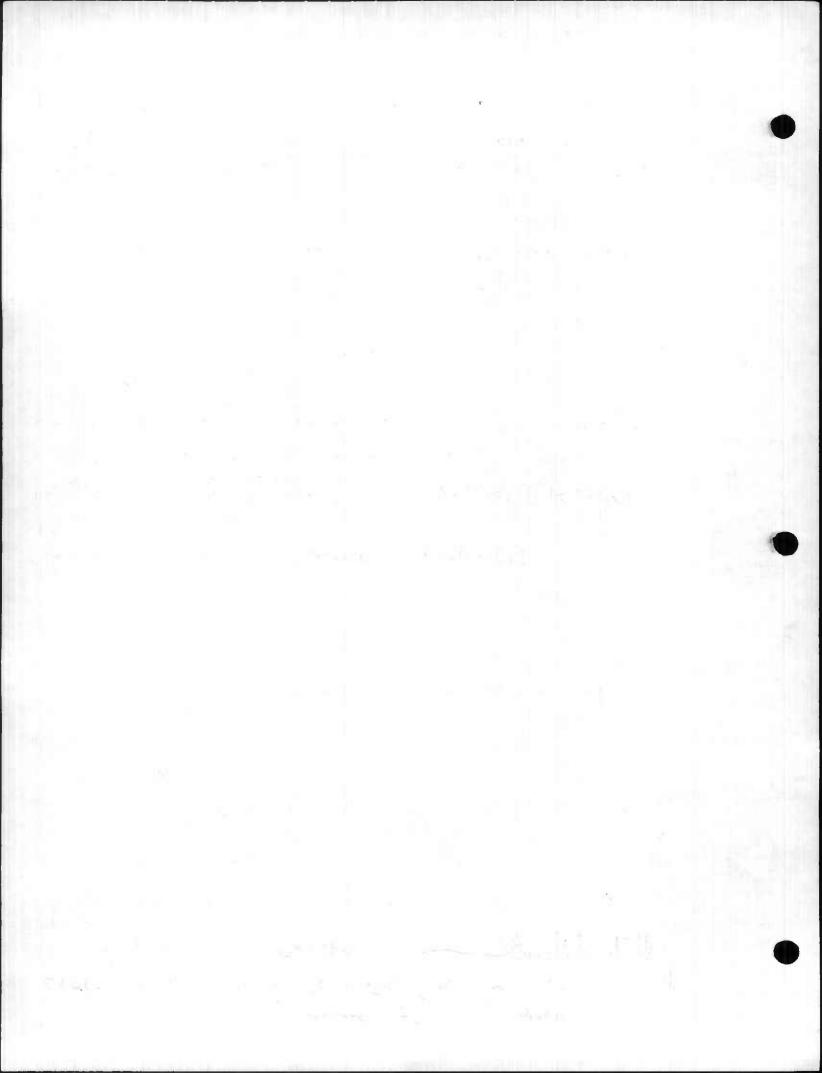
my Glan Burnie, MD21060



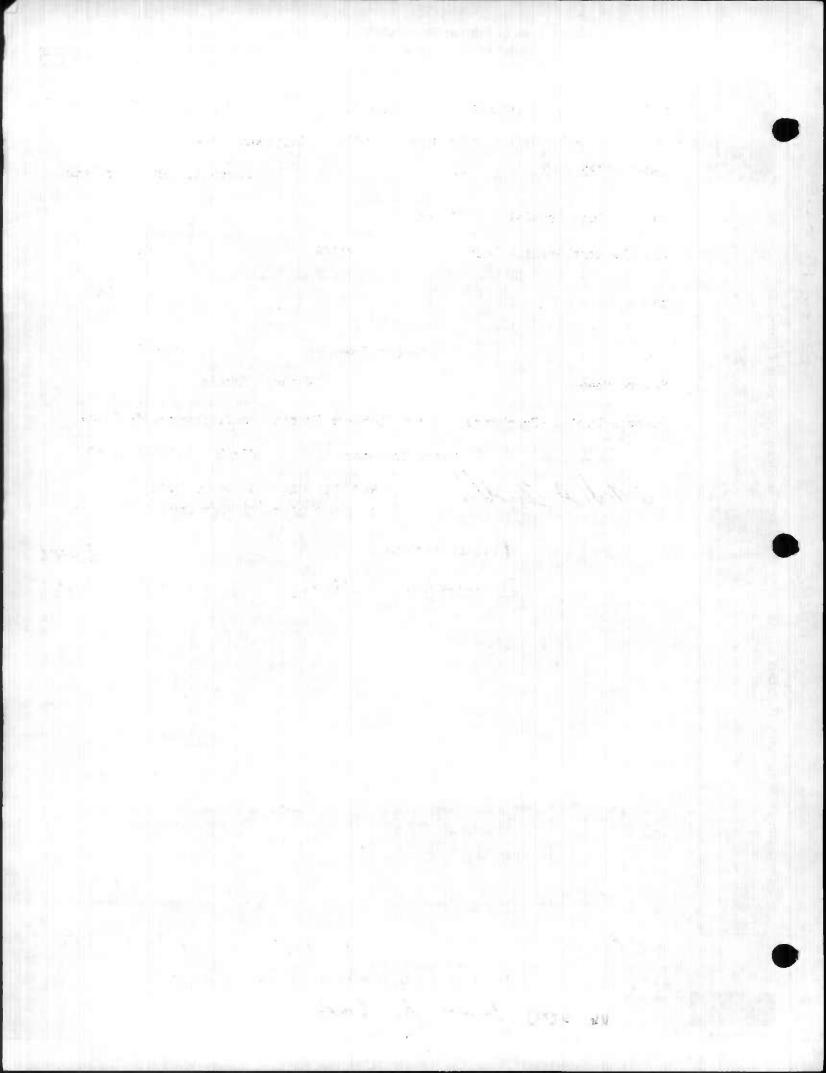
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3 Time of Death JULY Physician Mildred Evelyn Bradley 1999 8:20pm /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 8103 Philadelphia Road Rosedale Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth Month, Dey, APR 9, **Funeral** Birthplece (State or Foreign
Country) 1 □ M ধ 🗆 F Months Deys Hours 1912 214-50-2610 87 Yrs. Maryland **Director** Usual Residence of Decedent deeth with the Maryland to or 28a-f show 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Baltimore Rosedale 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8103 Philadelphia Road 21237 "natural", or items 23a USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ñ No If Yes, Give Year or Dates: Was Decedent of Hispenic OrlgIn? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Raca - American Indien Bleck, White, etc. filed within 72 hours efter 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☐ Xo Specify: Specify: Be Completed by 3 Nidowed 4 □ Divorcad White the Medical 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) i. Pages 1 and 2 should be filed witness of Health end Mental Etygien tant: If Item 27 is merked other thighry or other traumatic event, to Homemaker Own Home Baltimore, Maryland 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Amos Higgs Unk. Butler 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Roy A. Bradley/son 8103 Philadelphia Rd. Rosedale, MD 21237 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from State Department of Important: Many injury or Inc 7/7/99 Metro Crematory, Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22Cremartion Society of Maryland, Inc. F. McDonald Male 299 Frederick Rd. Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Onset end Deeth **Physician** Immediate Cause (Finel Endonetrial disease or condition resulting in death) **Examiner** Due to (or es e consequenca of) Examiner Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest bunial-tran Due to (or es e consequence of): The law requires that the death certificate be execu P.O. Box 68760, Physician/Medical the Due to (or es e consequenca of): Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Perf I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ sign be pege 2 should Completed 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4□ Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 2 No Certification: To this filled in by the funeral 27. Menner of Deeth Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 1 Naturel 5 Pending investigation 1 Yes within 24 hours efter death To the Funeral Diractor: A 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end pieca, end due to the cause(s) end manner steted. Medical 29a. Certifier completely (Check only one) To the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Neme end eddress of person who co eted cause of deeth (Item 23e) (Type, Print) Michae Me Balt. 9105 Franklin Squart Dr. 31. Dete filed (Month, Dev. Year) 32. Registrar's Signature State Registrar

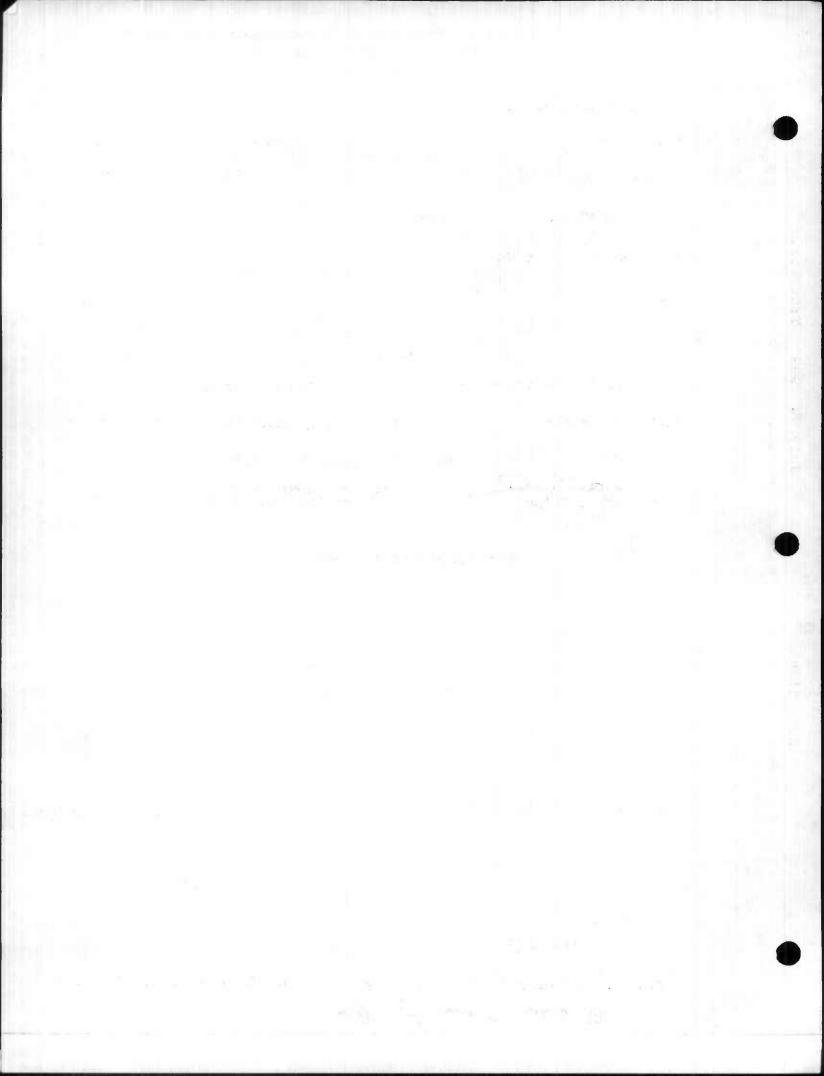


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Г	Funeral		5. Sociel Security Num	ber 6. S	өх	7. Age (In)	rs. lest birthday			If Under		8. Dete of Bi	rth		piece (Stete or Foreign	
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	or 28	Director	10e. Street end Number	er				10f. Zip C	ode				10g. Citizen	of Whet Cour	ntry?	
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	dea	Funeral	11. Marital Status		12. Was Dec	edent Ever i	n U,S. 13.	Was Deceder	t of I	Hispenic Orl	gin? (Spe	ecify Yes or No		Rece - Americ Bleck, White,		
21215-0020	should be filed within 72 hours efter death with the Maryland of Mental Hygiene. merked other than "natural", or items 23a or 28a-f show imetic event, the Medical Evanther must be notined at	by Fu	1 Never Merried 3 XWidowed 4		1 Yes If Yes, Gi Yeer or D	2 ∑X √lo ve		1 Yes 2			i, r dorto	1110211, 010.7			Vhite	
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Maryland			19a. tnforment's Name	s/Reletionship (Type, Print)		19b. Maii	ing Address (S	Stree	t end Numbe	er or Run	al Route Numb	er, City or To	wn, Stete, Zip	Code)	
	and salth		William Bi	shop/So	n		541	Clark	S	t., Sc	outh	Willian	nsport	, PA 1	7702	
ore	of He		20e. Method of Dispos		ID		b. Piece of Disp cemetery, cre	osition (Neme	of or ple	ce)		Dete	20c. Locati	on - City or To	own, Stete	
altimore,	Pag nent int: H		4 Donetion 5	□Other (Specif)	y)	emovel from Stete Balto. Wash. C				emato	ry 7	/11/99	Laur	Laurel, MD		
alt	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any Injury or other tra once.		21. Signeture of Fune	el Sepice Line	(O BED			2. Name and						salinin		
0	88 = 58		Michael J. Flagle Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093													
			23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, Shock, or heart failure. List only one cause on each line. Approximate Intervel Between													
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O.	requires that the death een signed by the atter hould be deteched for a	Physiclan/	Part II. Other significa	nt conditions co	ontributing to d	eath but not	resulting in the	inderlying ceu	se gi	ven in Pert I		23b. Dld	tobacco usa	contribute to	o the causs of death?	
P.O.	at the	Ph										10	Yss 2 1	lo 3 Pro	bably 4] Unknow	
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Records,	v require been si should	Completed											en eutopsy omed?	ev.	ere autopsy findings eileble prior to	
ecc	N S S	ple							-						mpletion of cause deeth?	
Œ	0 - 0	EO										10	Yes 2 N	0 1[☐Yes 2☐No	
Vital		Be	25. Was cese referred	to medicel						26. Plece	of Deeti	h (Check only				
>		ToE	exeminer? 1 Tes 2 No		Hospitai:	Inpatient 2	□ ER/Outpetie	nt 3 DOA	Ot	han				Other (Specif	y Hospice	
0		ü	27. Manner of Death			of Injury th, Dey Yee			. Inju	ry et ork?	T	28d. Describe				
Division of	ttending i death. :tor: After / the fune	atlo	1 XNeturei . 2 ☐ Accident	Pending investigation		ui, Dey 1661	tnjury	М		Yes 2	No					
<u>Vis</u>	or Attending after death. Director: Afte in by the fune	tific	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286. Place	of Injury - A	t home, ferm, st	reet, factory, o	ffice				(Street end N wn, State)	ım <i>ber</i> or Rura	al Route Number,	
	s effer N Director	Certification:	4 - Hollicido		Dulla	ing, etc. (Spi	эспу)					Ony or To	WI, 51010)			
	To the Hospital or Attending Phwithin 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier 1[(Check only one)	X Cartifying Phy Medical Exam	iner: On the b	best of my lasis of exem	knowiedge, deal Inetion end/or in	h occurred et avestigetion, in	the ti	ime, dete en opinion, dee	d plece, th occurr	end due to the ed et the time,	ceuse(s) and dete end ple	menner es s ce, and due to	teted. the cause(s)	
	To the within 2 To the comple	Me	29b. Signeture end title	e of certifier				29c. L	icen	se number			29d. Dete si	gned (Month,	Dey, Year)	
) Lu	4=			T) (1372) (-		7	1910	79	
			30. Neme end eddress	of person who	completed cause	se of death (tem 23e) (Type	Print)		(3 / 2	-1					
				riq Ma					a 1	lev F	Road	, Tim	onium	, MD	21093	
	Sta	te	31. Date filed (Month,									, = 2.11				
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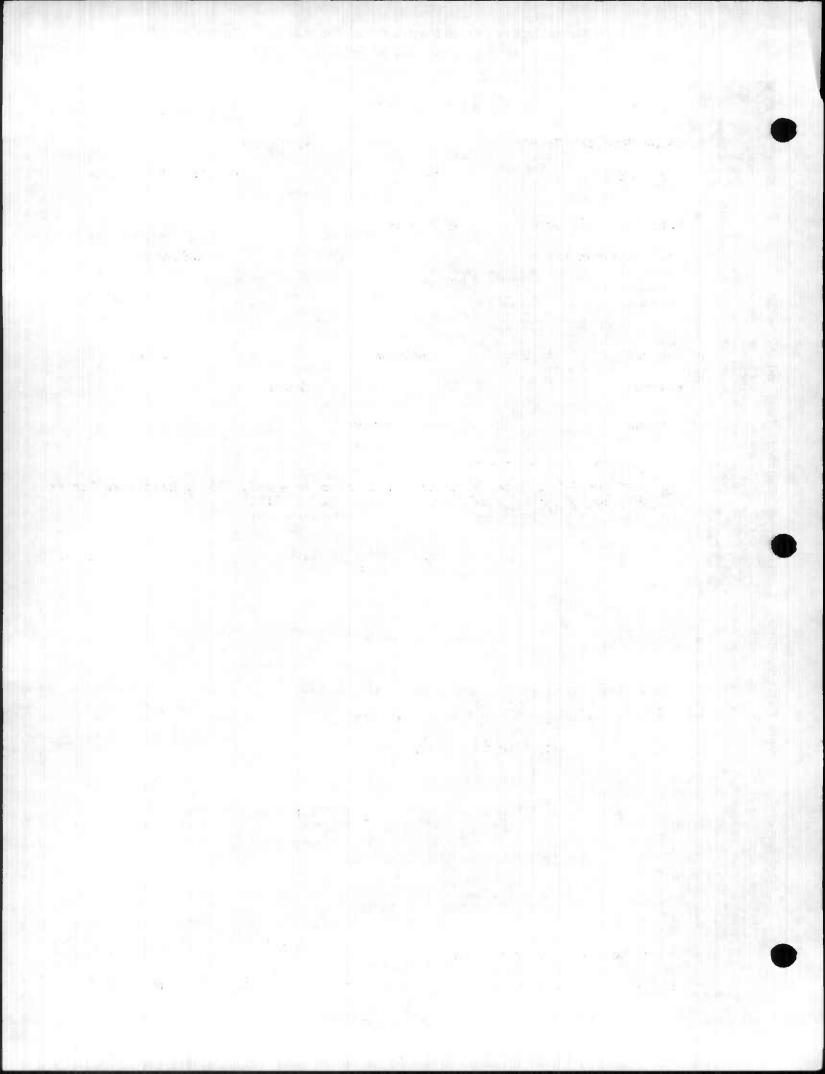
DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 21657

			(Certificate of	f Death		Reg. No.		-1001					
	1. Decedent's Name (First, Middle, La	est)	,			2. Date of De	eath Dey	Year	3. Time of Death					
Physician /Medical		Cult	ents	01)		TUNE		999	13:30					
Examiner	do Facilia, blome III and incideding at				4b. City, Town, or	Location of Deet	th 4c. County	of Death						
	Union Memorial Ho	spital			Baltimo	re								
Funeral		Sex 7. Age (In yrs. last birth	Months Dev			rth ay, Year)	9. Birthp	lace (State or Foreign					
Director	219-26-2933	IQ M 2D F	58 Y	rs.			8, 1940	unkne						
2	Usual Residence of Decedent 10a. Stete 10b. County	1	Oc. City, Town	or Location				10d. Inside City Limits						
Varylar f show led at	W 1 D-144		D 1						1 ☐ Yes 2X No					
viih the Ma t or 28s-f s be notified	Maryland Baltimo	ore	Baltimo	10f, Zip Code			10g, Citizen of	Whet Cour	itry?					
A Di Di		od.		2120			unknown							
n 72 hours after death with the Maryla "natural", or forms 23a or 28a-f show edical Examiner must be notified at letted by Furneral Director	11. Marital Status	12. Was Decedent Ev	er in U,S.	13. Was Decedent of	Hispanic Origin? (S	Specify Yes or No	o- 14. Red	e - Americ						
Pur Pu	1 Never Married 2 ☐ Married	Armed Forces? ∪ 1 ☐ Yes 2 ☐ No	inknown		iban, Mexican, Puer	to Rican, etc.)		ck, White,						
Par. o	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 □ N	o Specify:		Specif	v: bla	ick					
ed within 72 hours lygiene, her then "naturel", it, the Medical Exa Completed by	15. Decedent's E (Specify only highest gr	ducation	16a. [Decedent's Usual Occ	upation e dunna most of wo	rkina	16b. Kind of B	usiness/inc	dustry					
t within plans. The Mex	Elementary/Secondary (0-12)	College (1-4or 5+)		Give kind of work don life. DO NOT use reti	red)									
September O	unknown	ınknown	unl	known	40.00.00.00.00	(5") 4 6" 4-4"	unkn							
# 1 8 B	17. Father's Name (First, Middle, Las	")				me (First, Middle	e, Maiden Suman	n <i>e)</i>						
d Menta marked marked marked					unknown									
20 年度 20	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address (Stre	et and Number or R	u <i>ral Rou</i> te Numb	ber, City or Town,	, State, Zip	Code)					
1 and leath mm 27 ther tr	unknown 20a. Method of Disposition		20h Place of	unknown Disposition (Name of	I	Date	20c. Location	City or To	wn State					
Pages nert of any or o	1 Burial 2 Cremetion 3		cemetery	, crematory or other p	lece)	Date	200. Location	Oity of Te	, State					
	4 Donation 5 NOther (Special													
Departi Importi any inji	Ronald S. Wade, Director State Anatomy Board, 655 W. Baltimore Street Raltimore MD 21201													
	Baltimore, MD 21201 23 Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate													
	231 Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the one cause on each line.	e deeth. Do no	ot enter the mode of d	ying, such as cardia	c or respiratory	errest,	1	Interval Between Onset end Deeth					
Physician /Medical	Immediate Cause (Final		1	AA 1					7 () 2					
Examiner	disease or condition resulting in death)	a Multi	ple	Myelo	mg				mo					
		Di	ue to (or as a co	onsequence of);										
executed in and inel-transit		b						1						
exec in and fel-tra	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Di	Je to (or as a co	onsequence of):										
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iaw requires that the deeth ce es been signed by the ettend a 2 should be detached for us no leted by Physician/	Pert II. Other significant conditions	contributing to death but	not resulting in	the underlying cause	given in Part i.	23b. Did	i tobacco use co	ontribute to	the cause of death?					
by the	E. 1 St.	0	1			1	Yee 25 No	3 □ Pro	bably 4 Unknown					
gned be de	Ena Diage	2 Kenal	DIS	iease				7						
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The late he pege						10	Yes 2 No	1[☐ Yes 2☐ No					
sicien: The law requiring certificate has been sirector, page 2 should be Completed	25. Was case referred to medical				26. Place of De	ath (Check only	one)							
hysica his ce al direc	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Out	patient 3 DOA	Other: 4 Nursing	Home 5 ☐ Res	sidenca 8 🗆 Oti	ner (Specil	(y)					
Attending Physician: or death. octor: Atter this certifica by the funeral director,		28a. Date of Injury (Month, Day)	(ear) 28b. Ti	me of 28c. In W	jury at /ork?	28d. Describe	how injury occu	rred						
endir eath. or: A the fu	2 Accident Investigation			M 1	Yes 2 No									
ral or Attending P ratter death all Director: After the din by the funeration:	3 Suicide 6 Could not l 4 Homlcide determined		- At home, fan (Specify)	m, street, factory, offic	8	281. Location (Street and Number or Rurel Route Number, City or Town, State)								
C I I I I														
he Hospi in 24 hou he Funen pletely fill edicai	29a. Certifier 150 Certifying Pl	hysician: To the best of a miner: On the basis of e	xamination and	death occurred at the or Investigation, in my	time, date and place opinion, death occ	e, and due to the urred at the time	e cause(s) and m , date and placa,	anner as s	tated. o the cause(s)					
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29b. Signeture end title of certifier	and manner state	o.		nse number		29d. Date signs							
T v o	D C		_				-	77	1990					
	Prian S	peur M	D		.9645		June .	22)	1117					
	30. Name and address of person who	completed cause of dea	th (Item 23a) (1	Type, Print)	1 (0.1	0	111	- 01	10.0011					
	31. Date filed (Month, Day, Year)	Oar, W D	g56 s Signature	3/1 Char	vies St, S	AID B	altimor-	9,140	121207					
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Month **Physician** Elsie 8:05 pm L. Curley July /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner Stella Maris Hospice at Mercy Baltimore N/A If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** Days 1□M 2√F 218-22-2685 70 Yrs. April 4, 1929 MD **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A MD Baltimore City 152 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 1402 Belt Street 21230 United States items 23s Funeral 12. Was Decedanf Evar In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14 Raca - American Indian Black, Whife, etc. 1 ☐ Yes 2 ☑★lo If Yas, Giva Year or Dates: 1 ☐ Never Married 2 ☐ Married 8 1 ☐ Yas 2 ☑ No Specify: White P 3€Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Own Home 8 0 Homemaker 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) Be marked Edgar Allan Tudor Fannie Mae Naumann 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relaflonship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If them 27 is 1441 Towson Street BAltimore Maryland Patrick L. Curley / Son 20b. Place of Disposition (Name of cametery, crametery or other p Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Ramoval from State Glen Haven Mem. Park b July 12, 1999 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) Victor P. Doda, Jr. Charles L. Stevens Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not anfar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Rectal Canon Immediate Cause (Final disaase or condition resulting in death) **/Medical** Examiner Due to (or es e consequence of) Examiner ician and burial-trans Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): physician the buria Physician/Medical Due to (or as a consequence of): 88 usa 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Unknown signed b 2 24b. Were autopsy findings available prior to 24a. Was an autopsy periormed? Completed complation of causa of death? paga 2 cartificate has 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) SCIAMARIS ATMERCY 25. Was case referred to medicel examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 6 Other (Specify) hospite P 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 27. Menurer of Deeth 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? Certification: 28e. Date of Injury (Month, Day Year) Aftar Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident l or Attend after daatt Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, streef, factory, office building, etc. (Specify) 4 Homicide 24 hours a Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29e. Certifier Medical (Check only one)

29c. License number

St Poul PI

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Buldney,

29d. Data signed (Month, Day, Year)

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21207

and manner stated.

M)

32. Registrar's Signature

301

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Cusebery

Baltimore, Maryland 21215-0020

Box 68760

P.O.

Division of Vital Records,

Attending

Hospital

daath.

To the Within 2

29b. Signature and title of certifiar,

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JUL 0 9 1999

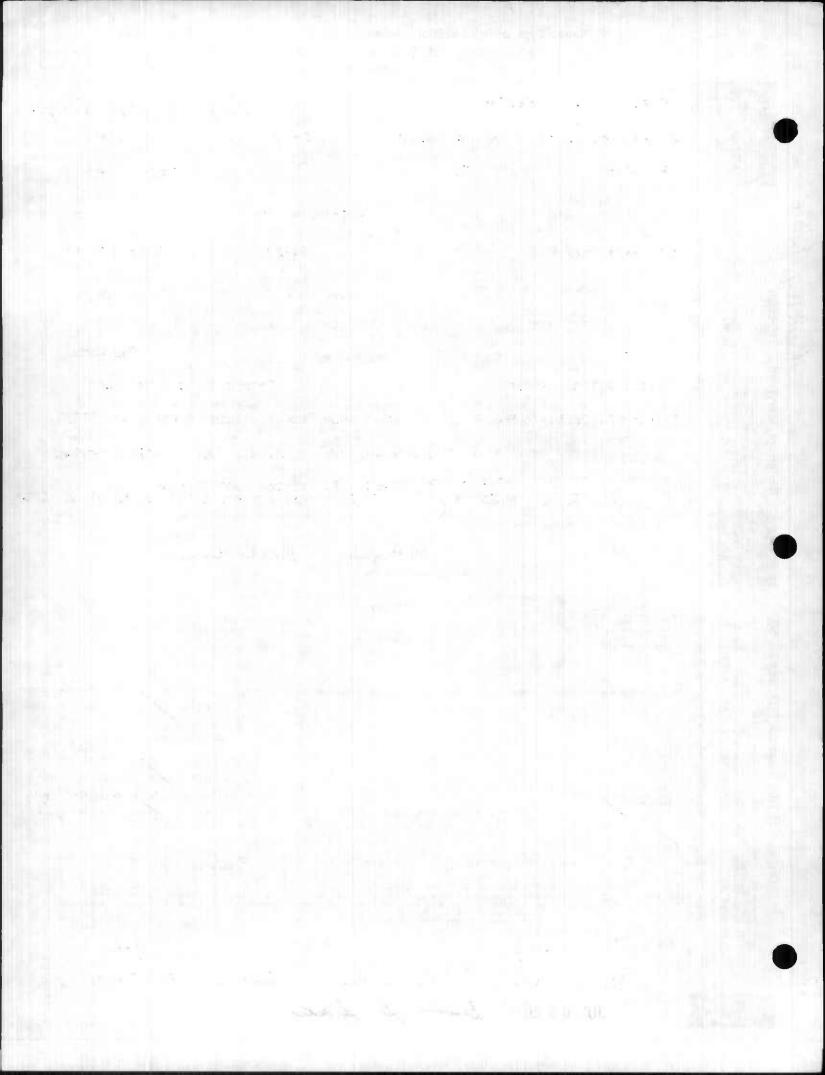
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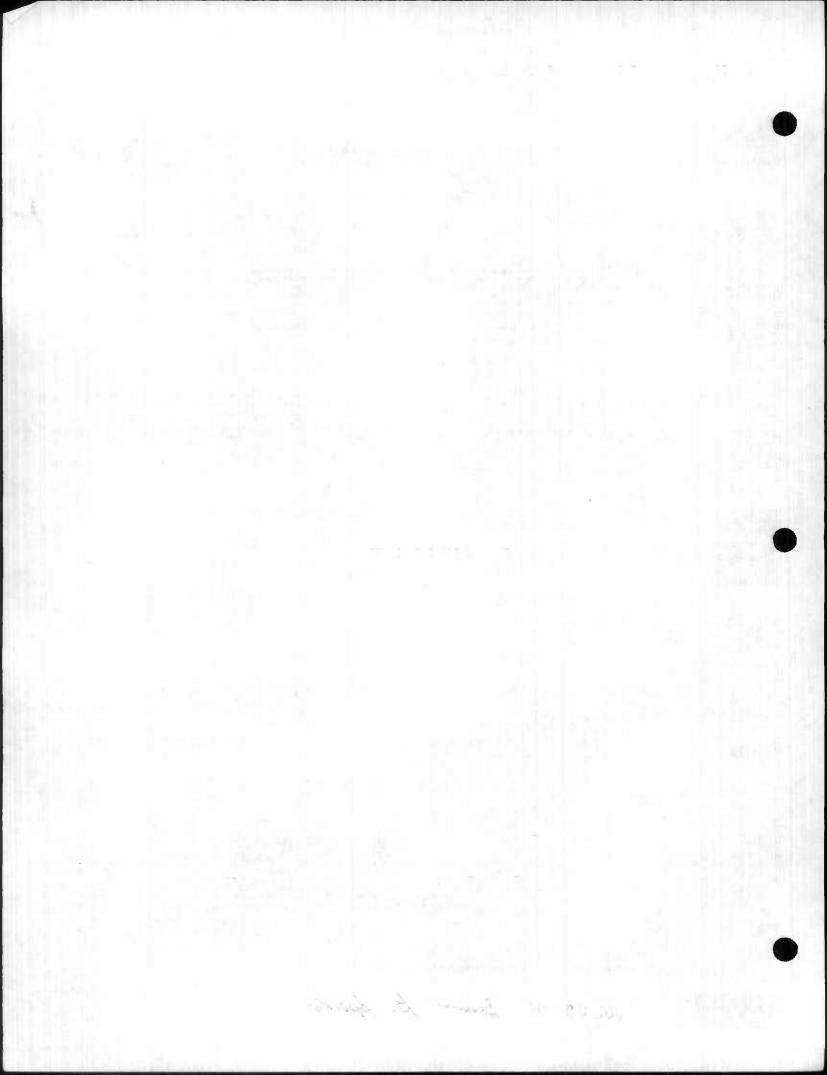
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State of Maryland / Department of Health and Mental Hygiene AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G773 7-23-99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month **Physician** 0515 AM tonio -ugene JULY 1999 /Medical 4c. County of De 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UNIVERSITY HOSPITAL BALTIMORE CITY

If Under 24 Hrs. 8. Date of H

Hours Min. If Under 1 Yaar 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) on (State or Foreign **Funeral** Months 64-0728 Days 1 M 2 F 220 Director ar Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County t0d. Inside City Limits 1 Yes 2 No Directo ary land 28a-f nore 2 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ART "natural", or flams 23s or 904 20 Funeral ania OX Wes Decedent of Hispanic Origin? (Specify Yas or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Evar in U,S. Armed Forces? 14. Race American Indian. 11. Merital Status Bleck, White, etc. 72 hours after 1 Never Married 2 Merried 2 No 1 Yes altimore, Maryland 21215-0020 1 Yes 2 No Specify: Yes. Give à 3 ☐ Widowed 4 ☐ Divorced Year or Datas: Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry flied within 7 Hygiene. other then "n Elementary/Secondary (0-12) College (1-4or 5+) 100 Pages 1 and 2 should be liked in ent of Health and Mental Hygis ent; if flem 27 is marked other N 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) å nomas 0 (Brother (Street and Number 19a. Informant's Name/Relationship (Type, 19b. Mailing Addrass er or Rural Route Number, City or Town, State, Zjp Code) Print) important: if ham 27 is a sary injury or Md. 21202 S ona 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, gremetary or other p 20c. Location - City or Town, Stete Dete 1 Burial 2 □ Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) reo Jesu 22. Name and Address of Facility

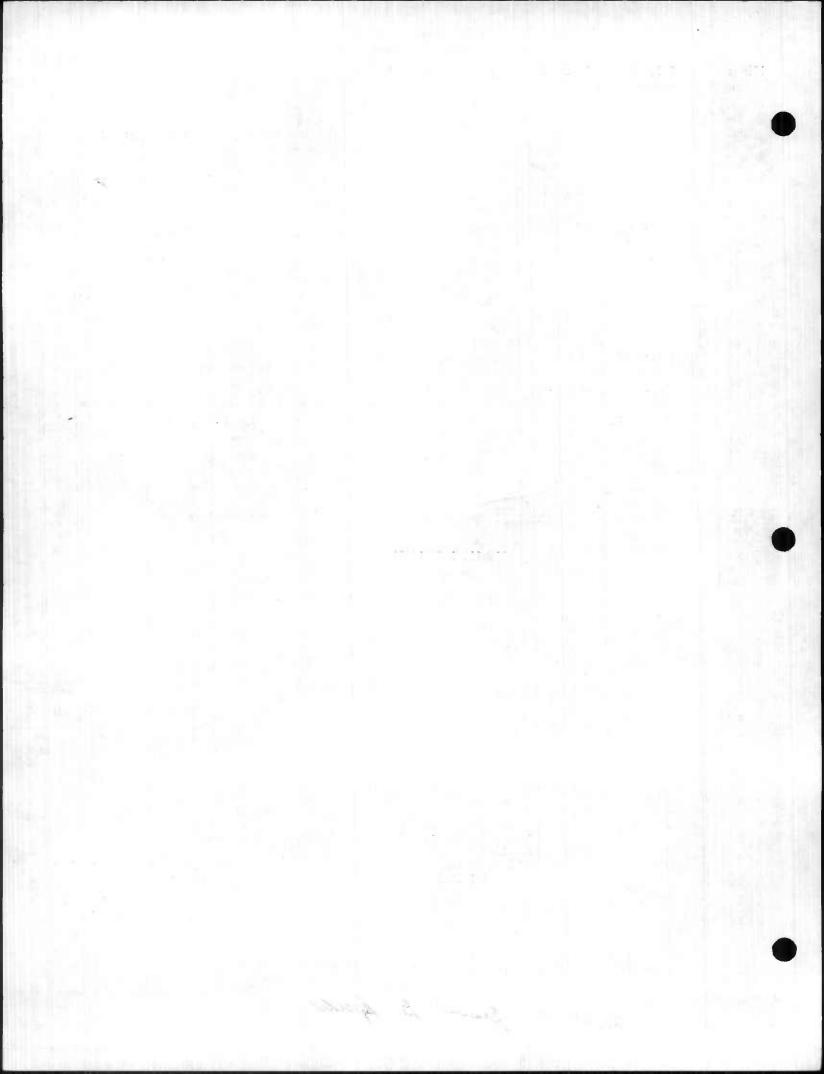
Joseph L. Ru. 21. Signature of Funaral Service Licenses tunera Home oseph W. North Ave. 2222 Balton or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ment to use. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediata Cause (Finel ACUTE NARCOTIC INTOXICATION disease or condition resulting in death) Examiner Dua to (or as e consequence of) Examin physician and the burial-transit be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated exercises. Dua to (or es a consequence of): Records, P.O. Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 685 Part If. Other afgnificant conditions contributing to death but not resulting in the underlying causa given in Part f. 23b. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 Unknown signed t by 24a. Was en eutopsy performed? 24b. Were autopsy findings eveilable prior to Completed peen completion of causa of death? page 2 s Yas 2 No of Vital Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Othar (Specify) XXXYes 2 No Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Dete of Injury (Month, Day Year) Our 0: 7-3-99 27. Manner of Death 28b. Time of fnjury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Attending 1 Natural 5 Rending invastigation death. 1 Yes 2 No UNKNOWN UNKNOWN Diractor: 2 Accident Could not be detarmined 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rure) Route Number. City or Town, State 9 04 PENNSYLVANIA AVE. To the Hoepital or Att within 24 hours after of To the Funeral Diract completely filled in by 4 Homicide FOUND AT HOME BALTIMORE, MD Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, data and place, end dua to tha causa(s) and mannar as stated. Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and plece, and dua to the cause(s) and manner steted. (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifiar 29c. License number Uniters OCME JULY 7, 1999 dennin 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) ennis . 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature 31. Dete filed (Month, Dey, 0 9 1999 State Registrar



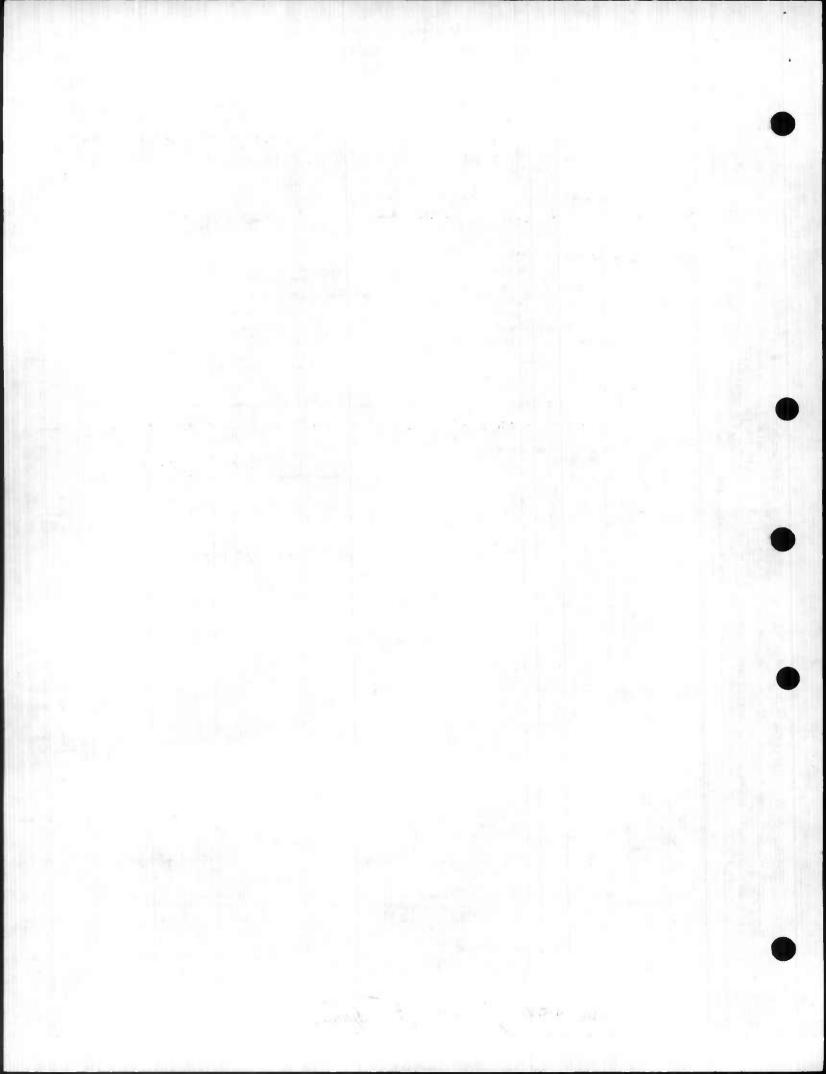
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State of Maryland / Department of Health and Mental Hygiene

Physician	1	ART I, 27, 28A-F PE Decedent's Nama (First, Middle	Last)						2. Data (of Death	Day	Year	3. Time o	
/Medical		BRIAN KEITH C.							JU	LY	6, 199	9	0705	O AM
Examiner		a Facility Nama (If not institution NORTH ARUNDEL I		er)				46. City, Town, GLEN B	or Location of URNIE	Death	4c. County ANNE		EL	
Funeral Director	1	. Social Security Number 215-04-9181 July Suel Rasidence of Decedent	6. Sex 7. 1 ☐ MM 2 ☐ F	Age (In yrs	. last birth	Month	der 1 Year ns Days		Hrs. 8. Deta of (Monta) MAY			9. Birthpla Countr BALTI		or Foreign CITY
show ides	-	Oa. State 10b. County		10c. C	ity, Town	or Location						100	d. Inside (City Limits
23a or 28a-f sho at be notified at al Director	I	MARYLAND BALT	MORE	J	BALTI	MORE							1 🗆 Yes	2 ₩ No
23a or 28a-f s ust be notified ral Director	1	0e. Street and Number				10f.	Zip Code			10	g. Citizen of V	Vhat Countr	y?	
Der must uneral		3226 GORHAM CO					2122				U.S.A			
by Funeral	-	1. Meritel Stetus 1. Naver Merried 2. Marri 3. Widowed 4. Divorced	12. Was Deceded Armed Force 1 Tas 2 If Yas, Giva Yaar or Date	No No	J,S.			Specify:	? (Specify Yes o uerto Rican, ato	or INO- :.)		e - American ck, Whita, at		
Completed		15. Decedent (Specify only highes Elementary/Secondary (0-12) 11TH GRADE	Education grade completed) College (1-4	or 5+)	16a. E		work done use retire	during most of d)	working		6b. Kind of Bu			MDITI
		7. Fathar's Nama (First, Middle, I	ast)			511	LAPI F.	ITTER 18. Mother's	Name (First, M		HEATING aiden Sumam		R CO.	NDTITE
To Be		EDWARD G. CAM	PION					LOIS	J. QUAL	LS				
		9a. Intormant's Name/Ralationsh	ip (Type, Print)		19b. I	Mailing Addra	ass (Street		r Rural Route N		City or Town,	State, Zip C	Code)	
		KAREN E. CAMP	ON (WIFE)		32	26 GOF	RHAM (COURT -	BALTIM	ORE,	, MARYI	AND	2122	7
lury or oth	2	0e. Method of Disposition 1 □XBurlal 2 □ Cramation 4 □ Donation 5 □ Other (Sp		ete	cemetery,	Disposition (# crematory of HILL (r other pla	ERY	7/12/	99	0c. Location - BROOKI			MD
any in	2	11 Signature of Federal Service L	Kensee						HOME, I		ORE. MA	RYT.AN	TD.	21229
dical niner niner	r	mmediata Causa (Final diseasa or condition asulting in death)	a. NARCO	Dua to (Dua to (or as a consequence of):									
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Physician/N	P	ert II. Other aignificant condition	s contributing to deat	h but not ra:	sulting in 1	he underlyin	g causa gi	ven in Part I.	23b.	Did tob	DACCO UNA COL	ntribute to	the cause	of death?
d be detached for use as										1 🗆 Yə	a 2□ No	3 Probe	ably 45	Unknown
2 shoul					7				24a.	Was an perform	autopsy ed?	com	a autopsy lable prior pletion of eath?	to
Page 2										10 Tras	s 2 No	16	Pos 20	□ No
director,		5. Was case referred to medical			<u> </u>			26. Placa of	Death (Check	only one	9)	1		
		examinar?	Hospital: 1 ☐ Inp	- 41	ER/Outp		DUA		ng Home 5)	
funer funer fon:	2	7. Manner of Death 1 □ Natural 5 □ Pending	28a. Dete of 1 (Month, Found:	Day Year)	Found		28c. Inju	ryat rk? Yas 2X⊟No			w injury occur	red		
To the Funeral Director: After the completely filled in by the funeral Medical Certification:		2 ☐ Accidant 3 ☐ Suicide 4 ☐ Homicida Substitute Could not be datarmined Found: 7-6-1999 28a. Place of Injury - At homa, ferm, street building, etc. (Specify) RESIDENCE						145 2/_110	28f. Local City of	NOWN ation (Street and Nymber or Rural Route Num or Town, State) 7424 HAWKINS DRI			RIVE	
pletely fille										the ce	use(s) and me			(s)
Somple Me		29b. Signature and the of certifier						se number		29	d. Data signe			
		30. Nema and address of person who completed (**) a of death (ftem 23a) (Type, Print)						.M.E.	231		JULY	8, 19	99	
10	3	O. Nema and address of person v					reet,	Baltim	ore, Ma	ryla	and 212	201		
State	3	1. Date filed (Month, Day, Year)	1999 32. Reg	istrar's Sign	ature	9. 4	pork	2						



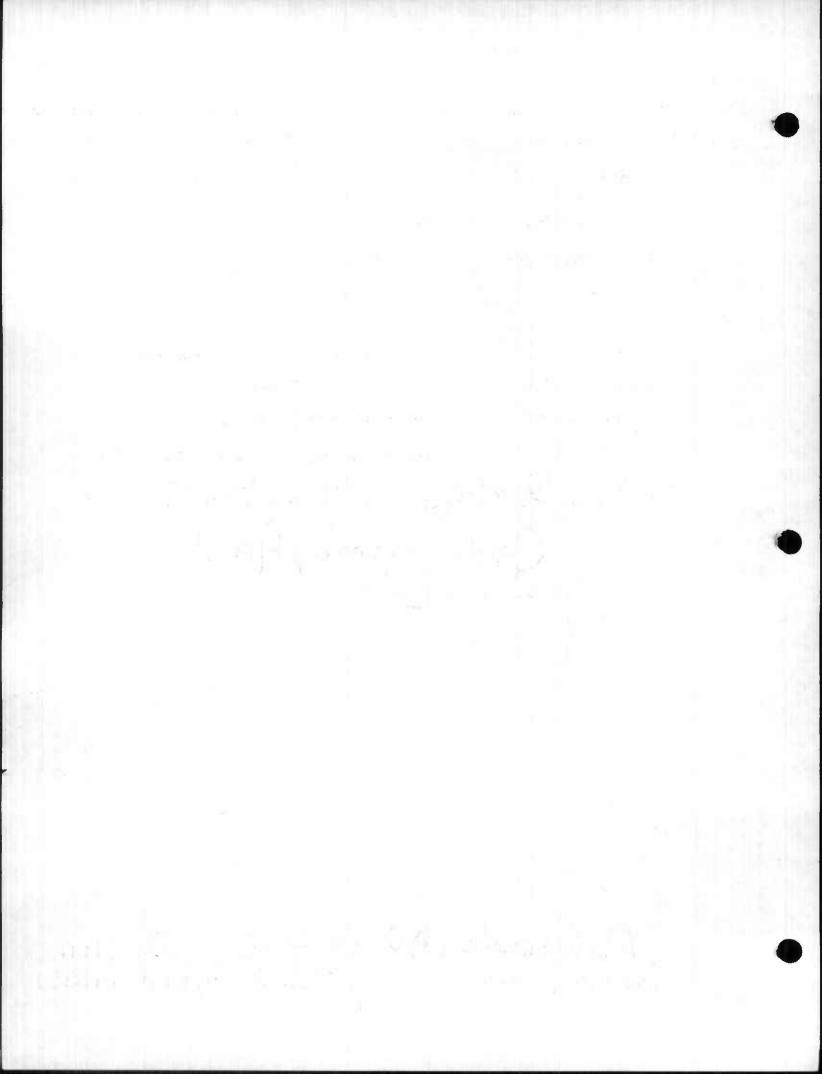
				Certificate of	Death	Reg. No.	
	Physician	1. Decedent's Name (First, Middle, Last	. Coope	ER	2. Date Moi Ju	e of Death oth Day Year	3. Time of Death
9	/Medical Examiner	4a Facility Name (If not institution, give NoRTHWE	street and number)		4b. City, Town, or Location of RANDAUST	of Death 4c. County of De	
	Funeral Director	5. Social Security Number 6. Se 220-07-9530	TM 2FTE	st birthday) If Under 1 Year Months Deys	Hours Min. (Mo	e of Birth nth, Day, Year) 9. B uary 4, 1922 M.	irthplace (State or Foreign Sountry) aryland
	Meryland of show fied at	10a. State 10b. County		Town or Location			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	ther death with the Menyland r Nems 23e or 28s-f show since must be notified at Funeral Director	10e. Street and Number 536 Congressional I	rive	101. Zip Code 21158	3	10g. Citizen of What C	
020	off, or he by Fu	3 ☑ Widowed 4 □ Divorced	12. Wes Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 to No If Yes, Give Year or Dates:	13. Wes Decedent of If Yes, specify Cult	Hispanic Origin? (Specify Ye an, Mexican, Puerto Rican, e Specify:	s or No- btc.) 14. Race - Arr Black, Wh Specify: W	nite, etc.
215-0	be filed within 72 hours eiter all Hyglene. I other than "naturel", or he yeart, the Moltes Emerical Second of the Completed by Fu	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4or 5+)	life. DO NOT use retire	during most of working	16b. Kind of Busines	s/Industry
and 21215-0020	BER O	8 17. Father's Name (First, Middle, Last)	0	housewife	18. Mother's Neme (First,		
aryia	2 should be and Mental is marked o sumatic every	Harry Floyd 19a. Informant's Name/Relationship (7)	(pe, Print) grand-	19b. Mailing Address (Stree	Lilliam Rah	Number, City or Town, State,	, Zip Code)
Baitimore, I	pemit. Peges 1 and 2 Department of Heelth Important: if Item 27 i any Injury or other tr ange.	Stacy A. Robertson 20a. Method of Disposition 1 X Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	lemovel from State 20b. Pie	don Park Ceme	tery 7/3/ ess of Fecility Loudon 3620 Wi	99 Baltimore Park Funeral Ikens Avenue Ore, Maryland	or Town, Steta , Maryland
x 68760,	bhysician We direct that the death certificate be executed by the ettending physician and bundarium at the condition of the	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a			FARCTION	Onset and Death
P.O. 9	The law requires that the death ce set has been signed by the ettendi page 2 should be deteched for use Completed by Physician/	Part II. Other algnificant conditions cor		ting In the underlying cause g	iven in Pert I. 23	b. Did tobacco use contribu	te to the cause of death? Probably 45 Unknown
of Vital Records,	es been signed of a should be dei		V	-13	24	a. Was an autopsy performed?	b. Wera autopsy findings available prior to completion of cause of death?
al Re	Comp					1□ Yes 2□No	1□Yes 2₽ No
on of Vit	Attending Physicien: The ridesth. setor: After this certificate by the funeral director, pagification: To Be Co	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1	28b. Time of Injury We		k only one) Residence 8 Other (Specifibe how Injury occurred	ecity)
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	Hospi 24 hou Funer Funer staly fill dical		ner: On the best of my knowledge. On the basis of examination and manner steted.				
•	within To the comme	29b. Signature and title of certifier	mi Mo	0	se number 3 7 3 3 3	29d. Date signed (Mod Ju N∈ 3	
		30. Name and address of person who co	mpleted cause of death (Item 2	23a) (Type, Print) , BALTO-	M02113	3	
	State Registrar	31. Date filed (Month, Day, Year) JUL 91	32. Registrar's Signetu	re 4 Long	61		



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth 3. Time of Death **Physician** Month Vee SUSAN COLBY 1999 JULY 10:25 am /Medical 4e. Fecliity Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner STILLMEADOW DRIVE **JOPPATOWNE** HARFORD If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Days Months 1□M 25 F 096 52 4821 Director June 27 1956 NEW_YORK Usuei Residence of Decedent the Maryland 10e, State 10b. County 10c. City, Town or Locetion 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or frems 23s or 28s-f shot traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD HARFORD **JOPPATOWNE** 10e. Street and Number 10f. Zip Code 10g, Citizen of Whet Country? 110 STILLMEADOW DRIVE Funeral 21085 USA 14. Race - American Indian, filed within 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. HOMEMAKER OWN HOME 17. Fether's Name (First, Middle, Lest) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked othe any injury or other traumatic event potes. 18. Mother's Name (First, Middle, Maiden Sumeme) Be (unk.) Hagadon (unk.) 2 19a. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mark Colby / husband 110 Stillmeadow Dr. Joppa, MD 21085 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Demeritt Cemetery 7-16-99 Peru. Maine 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility.
CVach/Rosedale Funeral Home 21. Signature of Funeral Service Licans e 1211 Chesaco Ave. Rosedale, MD enibe 23a. Part1. Enter the disease, or complications that caused the de III Do shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth but enter the mode of dying, such es cardiac or respiratory errest. **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examiner the buriel-trensi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting In deeth) Last Box 68760. ettending physician The law requires that the death certificete be Physician/Medical Due to (or as e consequença of) signed by the e Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings availeble prior to completion of cause of deeth? Completed 24e. Was an autopsy performed? peen s has certificate 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medica exeminer? Be 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 10 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 5 Presidenca 8 □Other (Specify) this funeral 27. Manne of Deeth 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 5 Pending Investigation 1 ☐ Yes 2 No 2 Accident B ☐ Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier Medical Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piace, and due to the deuters) and misimum as access.

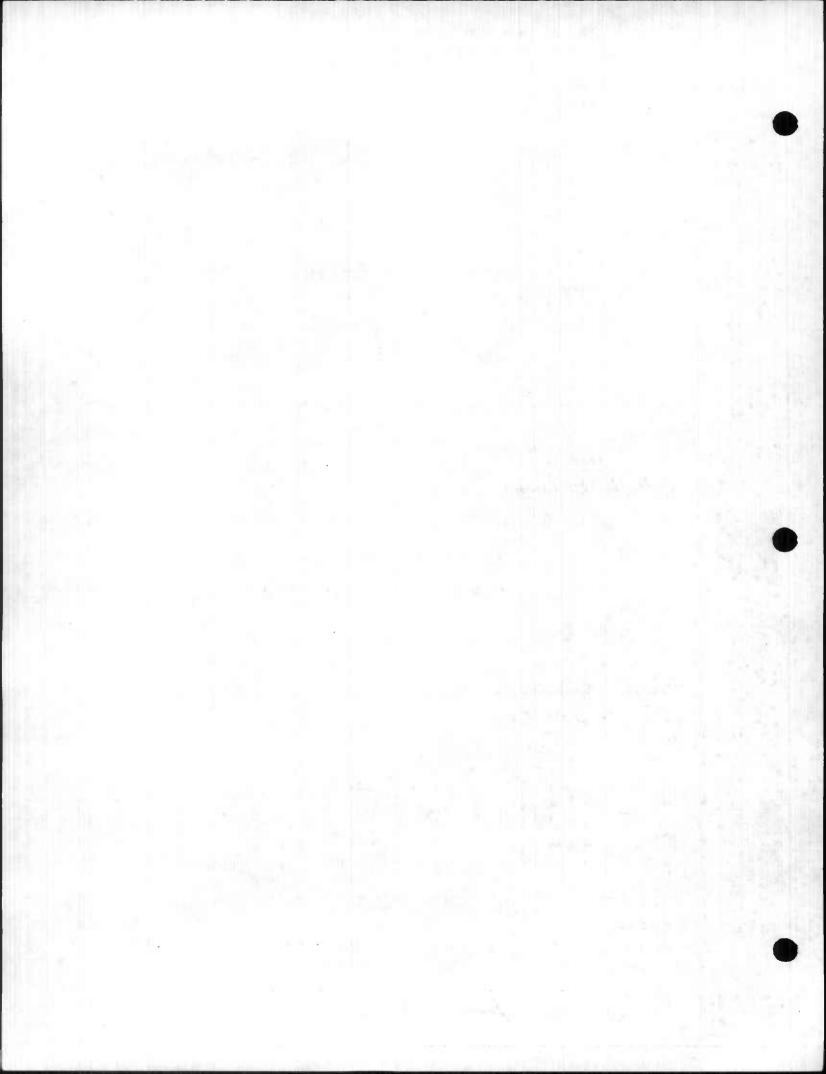
2 Madical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner/stated. (Check anly one) To the I within 2 29b. Signature a ompleted cause of death (Item 23a) (Type, Print) of person 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State 0 9 1999 Registrar



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State of Maryland / Department of Health and Mental Hygiene 9 9 21663

				Certifica	ate of	Death		Reg	. No.	Com	1000
	1. Decedent'a Nama (First, Middla, La	st)					2. Dat	a of Death	Day	Yaar	3. Tima of Death
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miner	4a Facility Name (If not institution, give	a street and number)				4b. City, Tow	n, or Location of	of Death	4c. County	of Deeth	
	17 Hillside Ave						wson		Balti		County
al	5. Social Security Number 6. S	TVM OFF	yrs. last bin	Yrs. H Und	er 1 Year Days			a of Birth onth, Day, 1	1925	9. Birthp	olaca (Stata or Foraign http:// lippines
r	226-70-5942 Usual Residence of Decedent	**	74	113.			Jun	e 15,	1925	Pnı	lippines
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Funeral	11. Marital Statua	12. Was Decedent Ever	in U,S.	13. Was Dec	edent of	Hispanic Origi	in? (Specify Ye Puerto Rican, a	s or No-			can Indian,
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l by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	WW2	10 162	2,0,1140	эрвану.			Specify	Asi	an Pacific
Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a.	Decedent'a Us (Give kind of v	vork done	during most of	of working	16	6b. Kind of B	usinass/In	dustry
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2	Licerio C. Ca						a Auror				
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	1 Burial 2 Cremation 3	Removal from Stata	cemeter	y, crematory or	r other pla						
	4 Donation 5 Other (Specif		Green	Mount	Crem	atory	7/8/	99 B	altimo	re,	Maryland
	21. Signature of Funeral Service Licer Martin D. Law	awsm		Mitch	ell-	wiedef	eld Fur	neral	Home,	Inc.	
				6500	York	Road.	Baltin	nore.	Marvl:		21212
Н	23a. Part1. Enter the diseese, or com shock, or heert tailure. List only	plications that caused the one cause on each line.	death. Do r	not enter the me	ode of dy	ng, such as co	ardiac or respir	atory arras	t,		Approximate Intervat Batween
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8	rasulting in death) Last	500	0 (01 83 8 0	on soquen toe or	1.						
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by 6	Type 2 Dial	ieres									
Completed by Physician/	A STATE OF THE STA						24	a. Was an	autopsy ed?	av	ara autopsy findings ailable prior to
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E O								1 🗆 Yes	2 🗆 No	1[☐ Yas 2☐ No
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Lo	1 ☐ Yas 2000No	Hospital: 1 ☐ Inpatient	2□ ER/Ou	tpatient 3 1	OOA O	her: 4 Nurs	sing Homa	Rasidan	ce 6 □Oth	er (Specil	y)
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Ē	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - building, etc. (S)		rm, street, facto	ory, office		28f. Loc City	cation (Stre y or Town,	et and Numb Stata)	er or Run	sl Route Number,
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Med	one)	and manner stated.			On Linna	na averbas		200	d Data signs	d /Month	Day Vass
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	thank Hou				- 314	17, 14.	•		4017	1	
	30. Nema and address of person who	completed cause of death	(Item 23a) (Type, Print)							
	David Madoff, M.	D., 5601 Loc	h Rav	en Blvc	. Ba	ltimor	e, MD 2	21239	1		
tate	31. Data filed (Month, Day, Year)	Oz. Tegistrat s c	dunature	9. 1	DOL M	1	,				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month 709 ominic Joseph /Medical Facility Neme (If not institution, give street and number) City, Town, or Location of Death **Examiner** runde EDICAL nnapolis Hrunde If Under 1 Year If Under 24 Hrs 5. Social Security Numb 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** y, Year) Bays Hours Director none Usual Residence of Decedent the Marylend 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits th end Mental Hygiene.
7 is marked other than "natural", or form 23e or 28e-f show transities event, my Medical Exeminent must be notified. 1 Yes No by Funeral Director Yasadena Hone 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 681 werside 11100 21122 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours efter nent of Health end Mental Hygiene. 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0020 3 Widowed 4 Divorcad Be Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None None 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Daniel Joseph DeCicco Kara Lin Hyry 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Health e Daniel J. DeCicco (Father) 681 Riverside Drive, Pasadena, MD 21122 20b. Pieca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department Inportant: If any Injury or 07/06 Metro Crematory Baltimore, MD 22. Name end Address of Fecility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervei Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical nonge Examiner Due to (or as a consequence of): Examiner touno the burial-transit The lew requires that the daath certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of) P.O. Box 68760, remoturity Physician/Medicai Due to (or as a co sequence of) use ata has been signed by the ette page 2 should be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobaccoluse contribute to the cause of death? 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificata 1 Yes 1 Yes 2 No or Attanding Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospitai: Other: 4 \sum Nursing Home Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Dey 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation Naturel To the Hospital or Attandii within 24 hours efter deeth. To the Funeral Director: A 1 Yes 2 No 2 Accident in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completaly filled edicai Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and piaca, and due to the ceuse(s) and manner es stated.

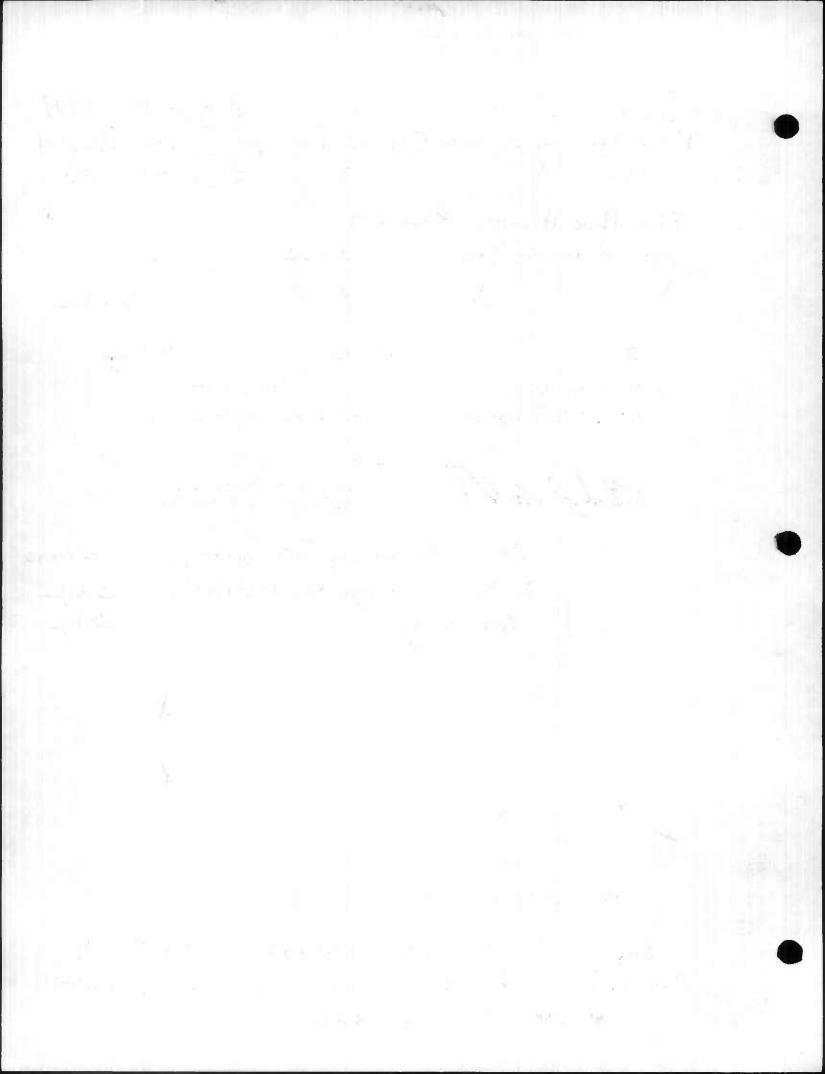
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) OO 30. Name and add ress of person who completed cause of deeth (Item 23a) (Type, Print) Kway, Annapolis, Md

DHMH 16 Rav 6/95

State Registrar inteleisch

31. Date filed (Month, Day, Year,

,2001



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21665 Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Dete of Deeth 3. Time of Death Month ne 0 4e. Facility Neme (if not institution, giva street end number) 4b. City, Town, or Location of Deeth TOWSON If Under 1 Year If Under 24 Hrs. Months Devs Hours Min. Genesis Eldercare: Cromwell Center Baltimore County Birthpiace (Stata or Foreign Country) 5. Social Security Number 7. Age (in yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months 1□M 2\ F Yrs 218-12-4825 75 October 10, 1923 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Baynesville Maryland Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8210 Emge Road 21234 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give X Yeer or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 TNo Specify: Specify. White 3 Widowed 4 Divorcad 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 yrs Clothing Designer Custom Clothing 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Surname) Louis Clifton Wood Lily Grace Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Colleen Lorenzen (Daughter) 20e. Method of Disposition 20b. F 1604 Jeffers Rd. Towson, Maryland 21204 20b. Placa of Disposition (Nama of camatary, cramatory or other place) Date 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Clynmalira Meth Ch Cem. 7/13/99 Monkton, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. John O. Mitchell, IV 6500 York Road, Baltimore, Maryland 21212 23e. Pertl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Better. Shock, or heart failure. List only one cause on each line. Onset and Deeth Immediate Cause (Final CORONARY diseasa or condition resulting in deeth) Hyper TENSION Due to (or as a consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ thknown SEIZUFE DISORDER 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Was en eutopsy performed?

Physician /Medical Examiner

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completely filled in by

P.O. Box 68760

Division of Vital

Hospital or Attanding Physician: 24 hours efter death. Funeral Director: After this certifice

To the Hospital within 24 hours e To the Funeral D

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Physician/Medical

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic evant, the Moulcol Examinat must be notified at

permit. Pages 1 end 2 should be filed within 72 hours efter or Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or item any Injury or other traumetic evant.

Baltimore, Maryland 21215-0020

the Maryland

Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only ona) examiner? Hospital: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Yes 2 No 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Watural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Descritifying Physicien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

IPULKUMAR 31. Date filed (Month, Day, Year) JUL 0 9 1999

29b. Signature and title of certifier

BHALDIYA MD 32. Registrar's Signature

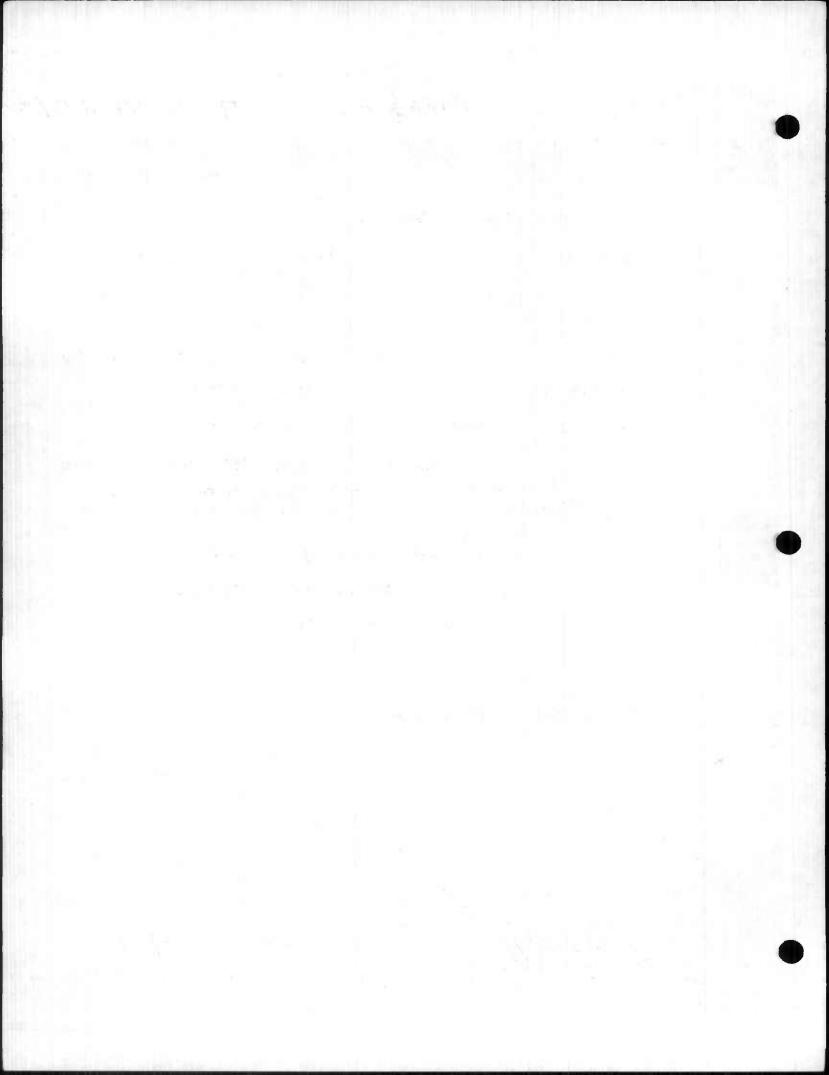
30 Name and address of person who commeted cause of death (Item 23a) (Type, Print)

E. MORTHERN PKWY, BALTIMORE 21214

29c. License number

52228

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death 07 Day 1999 Year JULY 20:06 ENGLISH KILLOUGH 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 04/10/1937 9. Birthplaca (Stata or Foreign Country) South Carolina 5. Social Sacurity Number 7. Aga (In yrs. last birthday) M 2□ F Months Days Hours Yrs. 251-60-0995 Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 □ No Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 1633 Ramblewood Road 21239 U.S.A. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ဩ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Navar Marriad 2 Married 1 ☐ Yas 2 No Specify: Black Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elemantary/Secondary (0-12) Collega (1-4or 5+) Truck Driver Furniture 18. Mothar's Nama (First, Middle, Malden Sumama) 17. Fathar's Name (First, Middle, Last) Robert English Emma Graves 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris English / Wife 1633 Ramblewood Road, Baltimore, Maryland 21239 20b. Placa of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 Cramation 3 Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) 07/13/99 Randallstown, Maryland King Memorial Park 22. Nama and Addrass of Facility The Derrick C. Jones Funeral Hm. 21. Signature of Funaral Sarvice Licania 4611 Park Heights Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications, a caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause a pach line. Approximata Intarvai Batwean Onsat and Daath Immediata Causa (Final disease or condition rasulting in death) sigo por one via Sequentially list conditions, if any, leading to Immediata causa. Enter Underlying Causa (Disaasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy periormad? 1 Yas 2 No 1 Yas 2 No 25. Was care rafarred to madical axarmar? 1 ☑ Yas 2 □ No 26. Placa of Daath (Check only one) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Inpatiant 2 PER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mann of Daath 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work?

Physician /Medical Examiner

Examiner

Physician/Medical

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Certification: To

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29b. Signature and title

Physician

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permit. Pages 1 and 2 should be filed within 72 hours efter death is Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a any injury or other traumatic event, he Medical Examine must once.

with the Maryland r 28a-f show

> attanding physicien and for use es the burief-transit signed by the a d be detached f been si cartificata has b

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attanding Physician: this funeral after deeth.

Director: Aft
d in by the fur in 24 hour. the Funeral Director of the filled in by To the Hosp within 24 ho To the Fune completely fi

> State Registrar

OMPLE 31. Data filad (Month, Day, Year)
JUL 0 9 1999

5 Panding

invastigation

6 Could not be datarmined

IANG 32. Registrar's Signatu

30. Nama and addrass of person who complated causa of death (Itam 23a) (Nov. Print)

28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify)

1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and manner as stated.

Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and mannar stated.

29c. Licansa number

D0035468

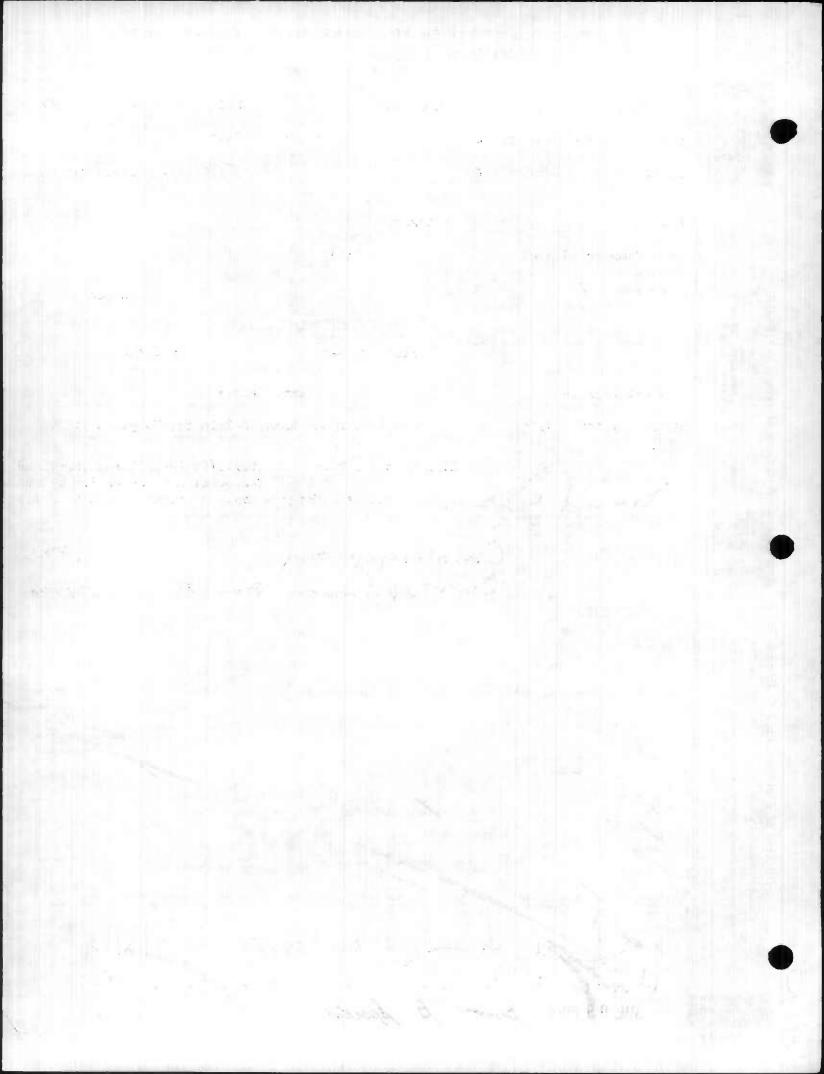
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Worth Cholse

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29d. Data signed (Month, Day, Year)

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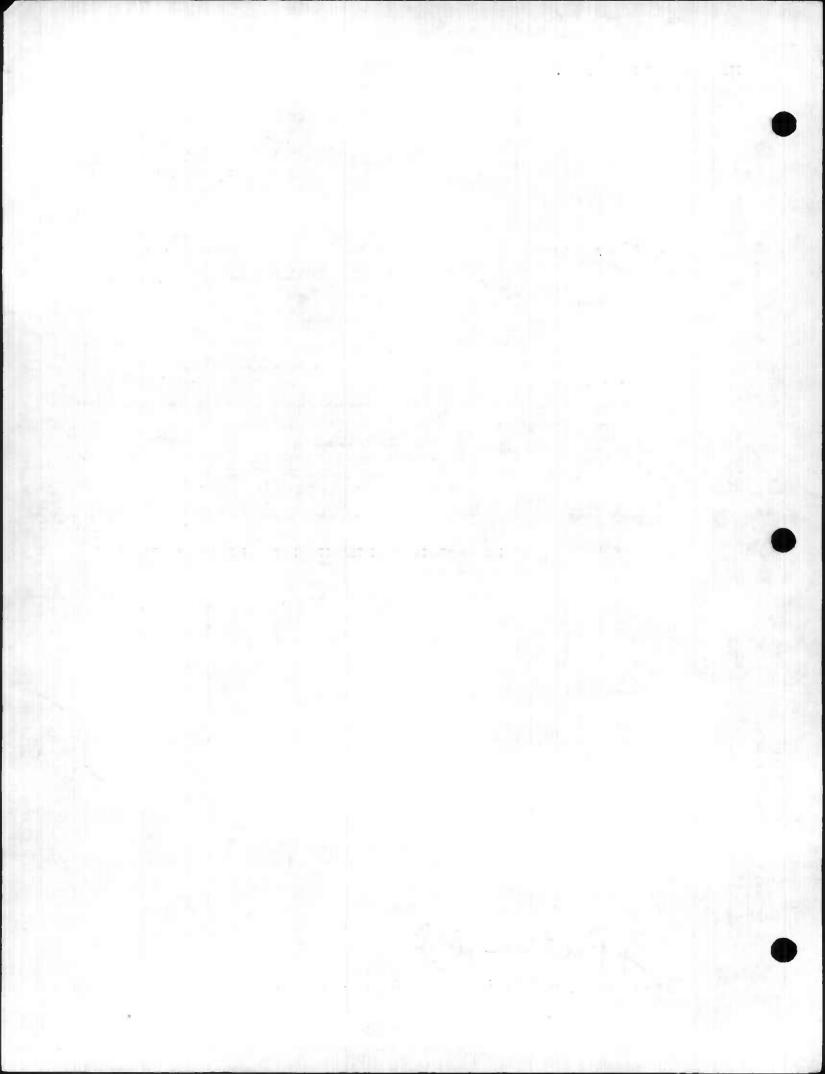
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** EDWIN JOHN 1999 9:20 Am 5 /Medical 4b. City, Town, or Location of Deeth 4e Facility Name (If not Institution, give street end number) 4c. County of Death Examiner HARBOR Sociel Security Number BALT If Under 24 Hrs. TIMORE TAL CENTER HOSP 7. Age (In yrs. last birthday) If Under 1 Yeer Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Days Hours 15M 20 F 212-32-5266 Yes 64 03 Director 20 1935 Md Usual Residence of Decedent with the Meryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 M Yes 2 □ No Director Md Anne Arundel Millersville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 102 Lahinch Drive 21108 IISA death v Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, 11 Marital Status Bleck, Whife, etc. filed within 72 hours after 1 Never Merried 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white If Yes, Give Yeer or Dates: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Businass/Industry i Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Broker Insurance 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) permit. Peges 1 and 2 should be file Department of Heelth, and Mental Hy Important: If Item 27 is marked oth any injury or other treumatic svent obtes. Be Odis Edwards Mary Walsh 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Judy Edwards/ wife 102 Lahinch Drive, Millersville, Md21108 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State Greenbrier Mem. Gard.7/9/99 Greenbrier W. 4 Donation 5 Other (Specify) ENtombmt 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Sterling Ashton SchwabFuneral Home, Inc Mark marshal 736 Edmondson Avenue, Balto, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediete Cause (Final DERICARDIAL WEEK disease or condition resulting in death) Examiner Examiner INOMA be executed Sequentially list conditions, if any, leeding to immediate cause. Enfer Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760, Physician/Medical Due to (or es e consequence of) signed by the aid be detached for P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yaa 2 No Records, þ 24b. Were autopsy findings available prior to completion of cause of death? should I 24a. Wes en eutopsy performed? Completed page 2 s 1 Yes 2 No 1 Yes 20 No certificate Division of Vital Hospital or Attending Physician: Be 25. Was case reterred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigetion 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) in by 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Cortifying Phyalcian: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature end fitte of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D P: 11950 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAL CENTER, MD-21225 TYUSH HARBOR HOSPI 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture. State JUL Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	#23 PART I, 27 PER MEI 1. Decedenl'a Name (First, Middle, L		Certificate of	f Death	Reg. 2. Date of Death Month	No.	3. Time of Deeth		
Physician /Medical	Cynthia Mar				JULY 01	, 1999	10:40 PM.		
Examiner	JOHNS HOPKINS E		1,000	4b. City, Town, or Lo BALT IMOF		4c. County of Death			
Funeral Director		Sex 1 M 2XXF	st birthday) If Under 1 Yea Months Days	r If Under 24 Hrs. s Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth Cou	place (State or Foreign		
ahow ahow	Usual Residence of Decedent 10e. Stale 10b. County		Town or Location		Dec. 28,		'yland 10d. Inside City Limits		
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h with	518 Robinson St	reet	21205		USA				
5-0020 72 hours after death with the Manyland natural; or items 23s or 28s-f show digit Esserios must be notified at steed by Funeral Director	3 ☐ Widowed 4 ☑ Divorced	12. Wes Decedent Ever in U,S Armed Forces? 1 Yes 2/D/No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Spe ban, Mexican, Puerto I o Specify:	cify Yea or No- Rican, etc.)	14. Rece - Ameri Bleck, White, Specify: Whi	, etc.		
	15. Decedent a E (Specify only highest gi Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Decedent's Usuel Occ. (Give kind of work don life. DO NOT use retir Apartment C		ng 16t	Security			
E doth	17. Fether's Name (First, Middle, Las	*			Neme (First, Middle, Maiden Sumame) ara Sharon Collier				
Baltimore, Baltimore,	20a. Method of Disposition 1 Method of Disposition 1 Description of Disposition 2 Description of Disposition 3 Description of Disposition 4 Donation of Disposition 5 Description 23a. Pert1. Enter the disease, or corshock, or heart feiture. List only Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	De to (or a d	Do not enter the mode of dy MIA ASSOCIATED W as a consequence of): as a consequence of):	ress of Fecility lenss-Seitz Is Road, B ring, such es cardiac o	Funeral altimore respiratory errest.	Home, Inc., Maryland	Maryland		
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or Attending after deeth. Director: After In by the fune ertification	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not learnined	(Month, Day Year)	Injury W M 1[Yes 2□No		t and Number or Rui	ral Route Number,		
em Rospital hin 24 hours the Funeral npietaly filled		hysician: To the best of my knowledge. To the basis of examinetic and manner steted.	edge, death occurred at the n and/or investigation, in my	time, date and place, e opinion, death occurre	end due to the caused at the time, date	e(s) end manner as a end place, and due	stated. to the cause(s)		
To the common N	29b. Signature and title of certifier	tane, M.	D.	O.C.M.E.		Dete signed (Month) JLY 02, 19			
State	30. Name and address of person in the state of the state		1 Penn Street	, Baltimor	e, Maryla	and 21201			



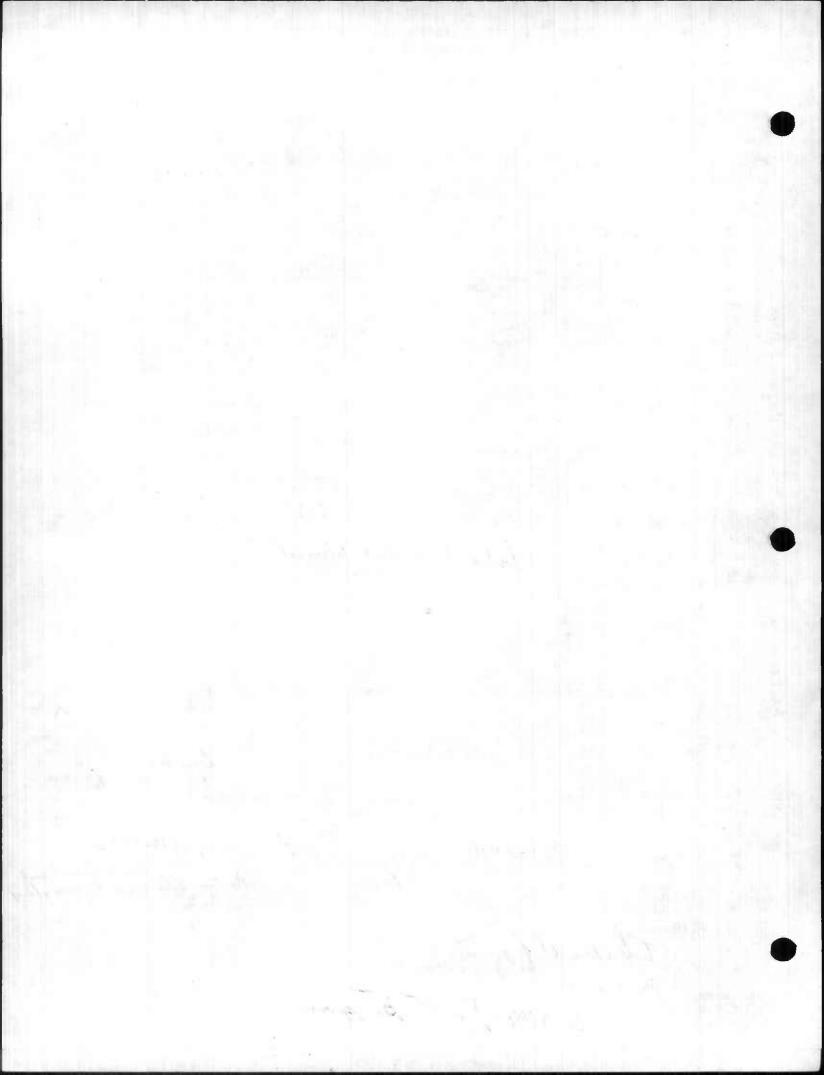
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State of Maryland / Department of Health and Mental Hygiene 99 2 | 669

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Physician /Medical	Ph	ilip Joh	n Fr	У				JULY			3:05 PM.	
Examiner	4e Facility Name (If not institution, gi					48	o. City, Town, or	Location of De		ty of Death		
	14 QUIET ST 5. Social Security Number 6.				M Had	er 1 Year	COCKEYS If Under 24 Hrs			ltimo		
Funeral Director	220-70-0991 X M 2 F 29 Yrs. Months Days Hours Min. (Month, Day, Year) JULY 15, 19								Day, Year)		place (Stata or Foreign ntry) cyland	
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or 28a-1 show be notified at Director		imore		, , , , , , , , , , , , , , , , , , , ,							1 ☐ Yes 2 ☐ No	
or 28a-f	10e. Street and Number	Illore			_	imoni	um		10g. Citizen o	(What Cour		
	14J Quiet St	ream Cou	rt			2109			Ţ	JSA_		
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and and and and and and and and and and	19a. Informant's Name/Relationship										State, Zip Code)	
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or the sched	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death?			
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rector, p	25. Was case ratarred to medical examiner?							eath (Check onl	y one)			
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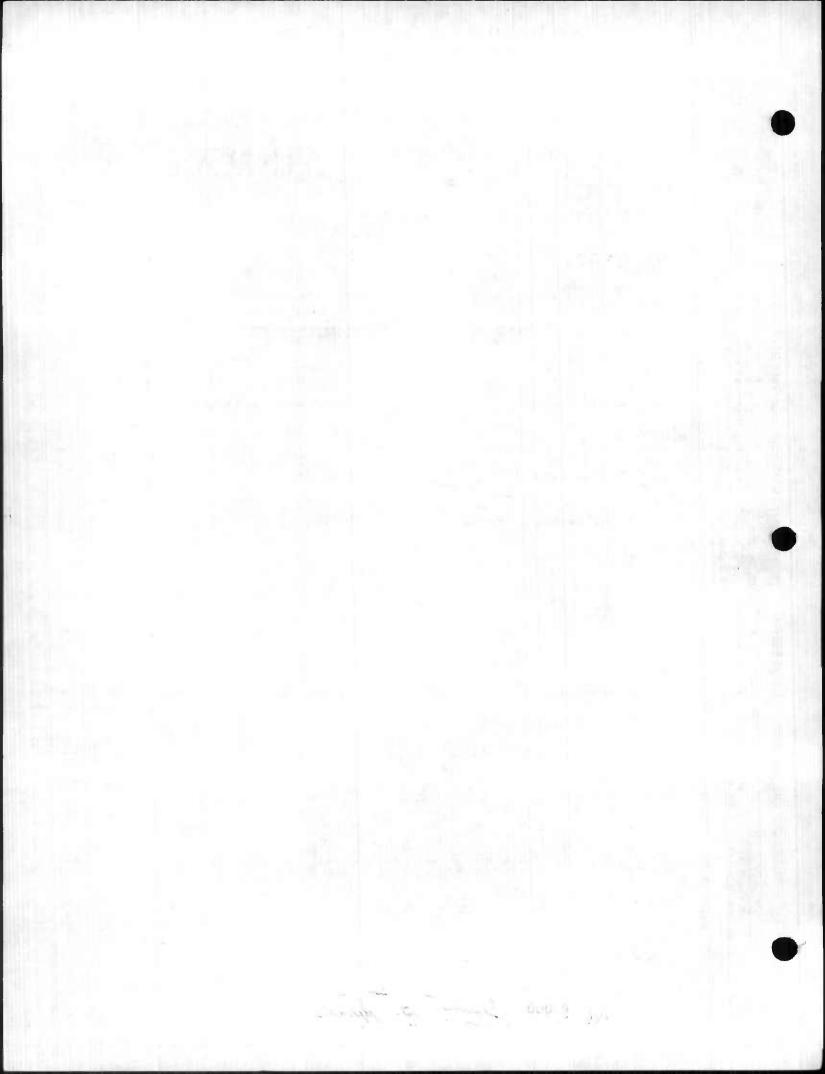
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician 1999 FREDA **FARBER** JULY 6 3:40 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT. 3, 1910 If Under 1 Year 5. Social Security Number 113-22-8776 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Deys Hours 1□M 21 F 88 NEW YORK Director Usual Residence of Decedent the Maryland 10e. State 10b. County 10c. City. Town or Location show 10d. Inside City Limits BALTIMORE RANDALLSTOWN 1 Yes 2 No Director MD must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Berns 23a 4010 AMY LANE 21133 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Status Black, White, etc. filed within 72 hours after Hygiens. Wher than "natural", or the 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: WHITE Specify: ğ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If Item 27 is marked other
any Injury or other trausment other altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumame) å ISAAC SILVER **ESTHER** UNOBTAINABLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 4010 AMY LANE RANDALLSTOWN, 21133 MD MRS. MEIRA FISHMAN(DAUG.) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Deurial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) CEDAR PARK 7/8/99 PARAMUS, NJ 21. Signature of Sunegar Service Licens SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that around the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Finel SEPSIS disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physicien and the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): for use as 88 signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown BSCESS Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed SETES MELLITUS ANCREATIC 2 1 No 1 Yes 2 No cartificate Division of Vital or Attending Physicien: 8 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Certification: To Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 21 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation After Natural after deeth. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide • Funeral Dire Hospital LEC Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated. 29a. Certifier completaly (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 \$ 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 99 lee 30. Name and address of person who completed cause of death (ty m 23a) (Type, 21208 1220 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY 7, PEARLE FINE 1999 9:20 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth SUNRISE ASSISTED LIVING BALTIMORE BALTIMORE If Under 24 Hrs. Dete of Birth (Month, Day, Year) DEC. 9, 1904 If Under 1 Year Months | Days 5. Social Security Number Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) Hours 1 M 20XF 94 Yrs. 220-07-1977 VA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3705 DURLEY LANE 21207 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces7 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□ Yes 20 No Specify: Specify 3₩ Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) WILLIAM BROWN REBECCA FINKLESTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) WILLIAM FINE / SON P.O. BOX 5800 - BALTIMORE, MD 21282 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State tery, crematory or other place) 1X Burial 2 ☐ Crege 3 Percyalitrom State SHAAREI TFILOH CEMETERY 7/9/99 4 Donation 5 Other (Sepcify) WOODLAWN, MD 21. Signature of Fundral St 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 of carrier cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximete Intervet Between Onset and Death 23a. Part1. Enter the shock, or head Immediate Cause (Final disease or condition resulting in death) cerebravasciller accident week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as e consequence of): Due to (or as a consequence of): Part fl. Other significant conditions confributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown GASTROINTESTINA

Physician /Medical Examiner

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permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If New 27 is marked other
any Injury or other to:

altimore, Maryland 21215-0020

68760

Box

P.O.

Records,

Division of Vital

RENAL FARURE HYPOTHY ROIDISM

24a. Was an autopsy performed?

24b. Were autopsy findings svailable prior to completion of cause of death?

1 Yes 2 2 No 26. Place of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical axaminer? 1□ Yes 20 No

28e. Dete of Injury (Month, Day Year)

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28d. Describe how Injury occurred

Assisted Other: 4 Nursing Home 5 Residence 6 OOther (Specify)

27. Menner of Death 1 Matural 2 ☐ Accident

3 Suicide

4 Homicide

5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 52360 29d. Date signed (Month, Day, Year)

wo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KULBIR SANDHU - 1838 GREENE

PRCESULE TREE ED SUITE 300 MO21208

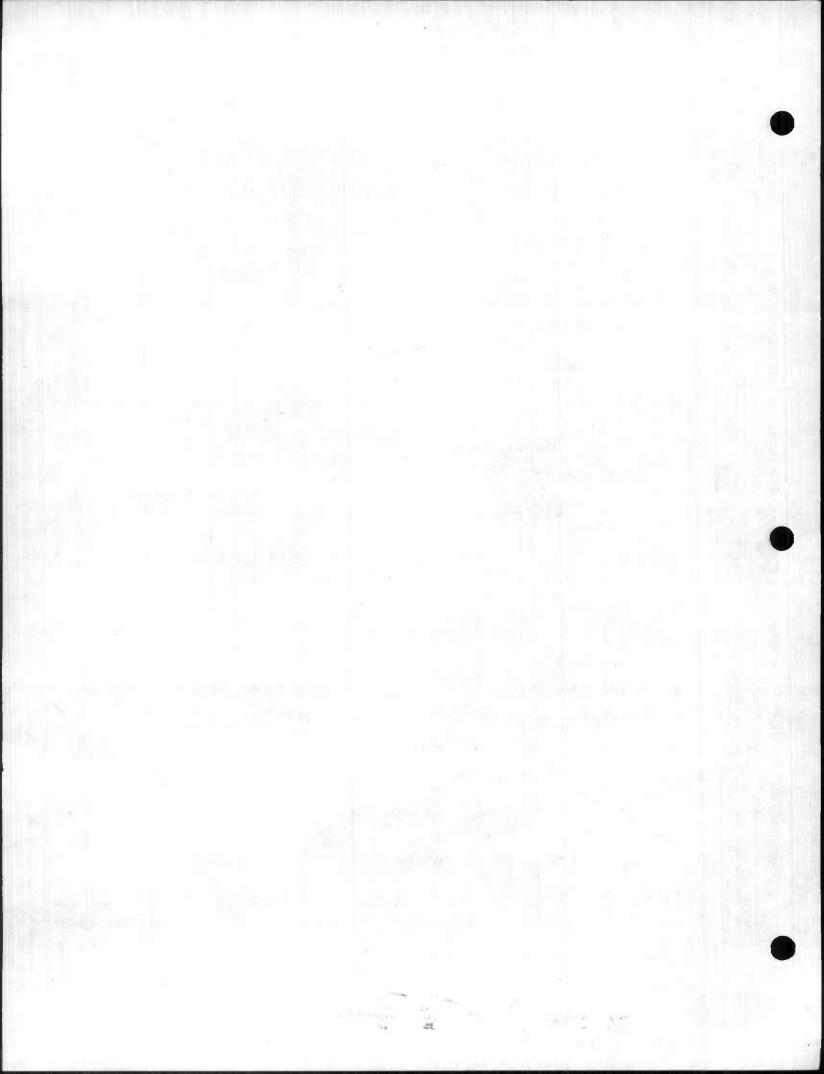
State Registrar

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31. Date filed (Month, Day, Year)

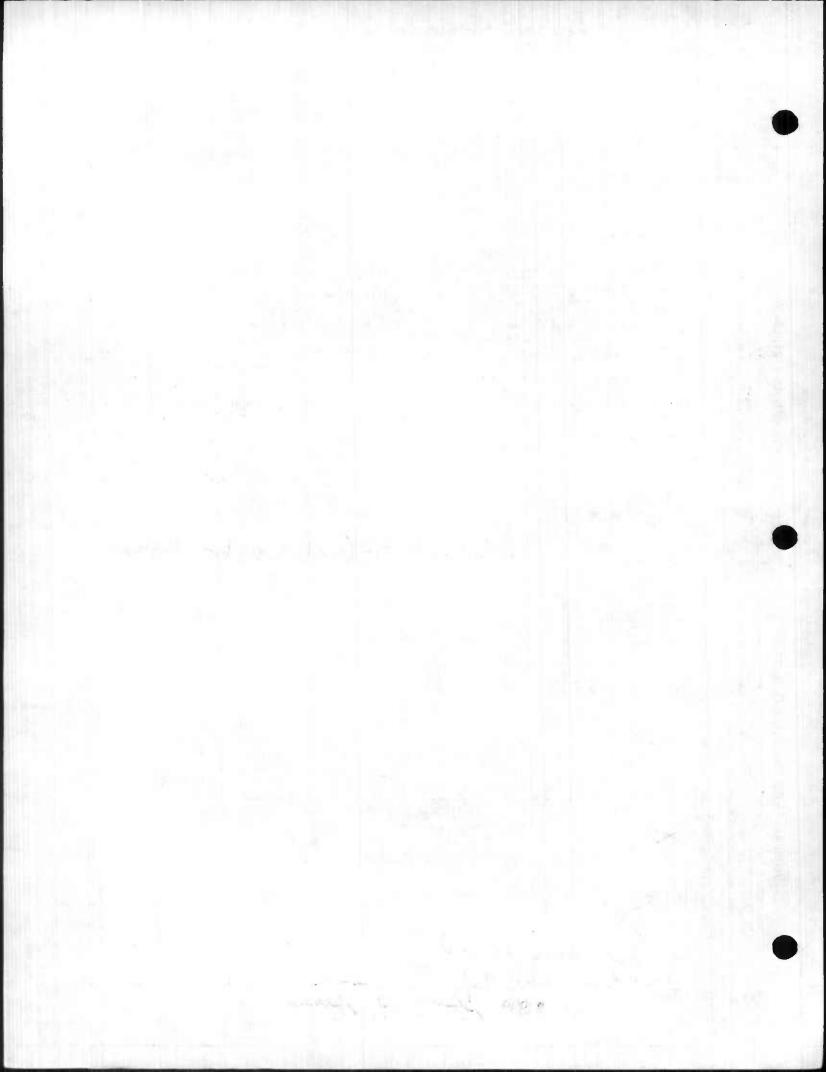
32. Registrar's Signature



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene QQ 21672

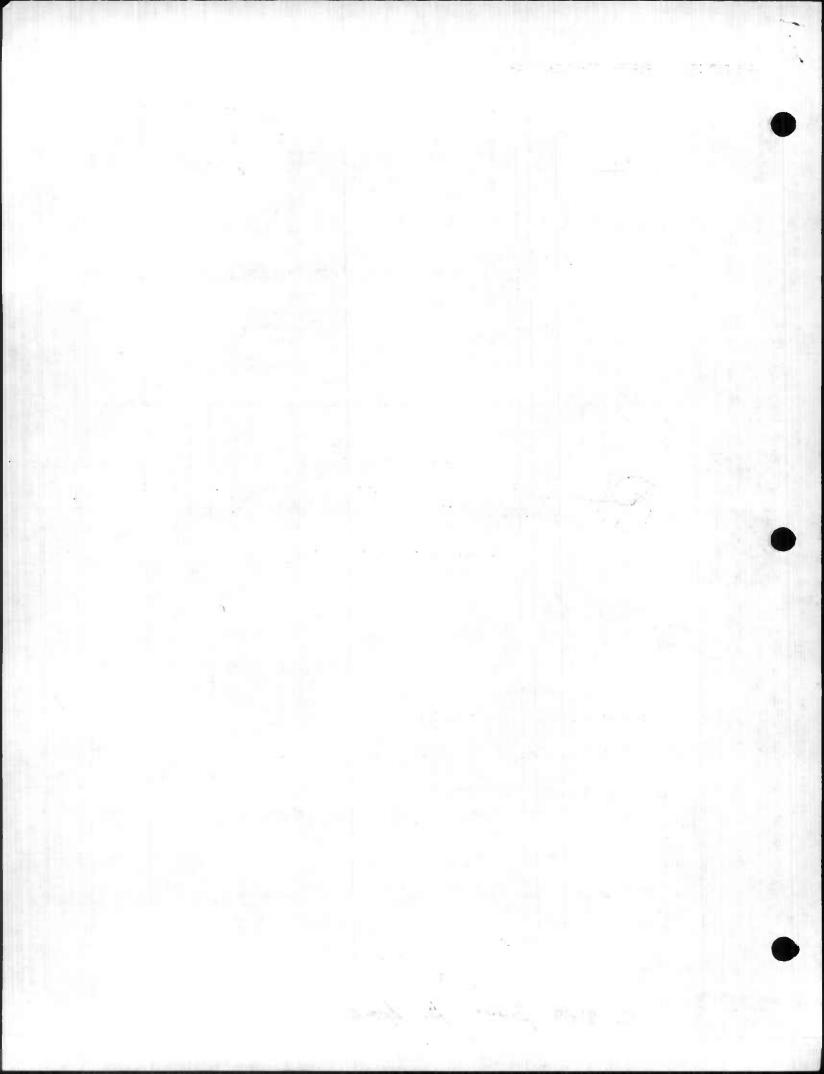
bert Grand	Y.Y			,	Cert	tificate of	Death	R	eg. No.	3 4	1012	
Dhusisia		I. Decedent's Nama (First, Middle,						2. Date of Deal Month	h Day	Year	3. Tima of Death	
Physicia /Medica	_	Robert	A. Grand	У				July 0	4, 1999)	10:43 A.M	
Examine		4s Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death										
		1837 North Chap				BTI-d4 V	Baltin		N/A			
Funeral Director		5. Social Security Number 219-01-0564 Usual Residence of Decedent	3. Sex 7. A	79	last birthday) Yrs.	Months Day		8. Data of Birth (Month, Day, 04-08	Year)	9. Birthple Count	ace (State or Foreign	
hend we		10a. State 10b. County		10c. Ci	ty, Town or Loca	ation				10	d. tnside City Limits	
Mery Heah	ğ	MD N	A	E	Baltimo	ore					1 Yas 2 □ No	
or 284	Director	IOe. Street and Number				10f. Zip Code		1	Og. Citizen of V	What Count	ry?	
th wi	[B]	1837 N. Chap	el Street			21:	213		USA			
020	by Fur	Marital Status XIXNever Married 2	12. Was Deceder Armed Forces 1 12 Yes 2 If Yes, Giva Year or Datas	?) No		as Decedent of Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		e - America :k, Whita, a	lc.	
72 hours	100	15. Decedent's	Education		16a. Decede	ent's Usual Occi	upation	dina	16b. Kind of B	usiness/Indu	ustry	
1d 21215-0020 elled within 72 hours at other than "natural", or other than "natural", or	Completed	(Specify only highest Elementary/Secondary (0-12) 10th Grade	College (1-4o	5+)			e during most of worded) ologist	King	Bronx	, N.3		
Maryland 212 2 should be filed with a marked other than reumetic event, to a	To Be C	17. Father's Name (First, Middle, Last) Charles E. Grandy 18. Mother's Nama (First, Middle, Maiden Surname) Mary Chase										
Der.		19a. Informant's Name/Ratationshi Mary Grandy	(Type, Print)				et and Number or Au l Circle					
	2	20a. Method of Disposition 1 Burial 2 Cremation 3 Removat from Stata 4 Donation 5 Other (Specify) 20b. Place of Disposition (Nama of cematary, crematory or other place) Garrison Forest VA Cem. 07-09-99 Owing										
Baltimo pemit. Page Department of Important: If any Injury or once.	1	21. Signature of Funeral Service Li	censee			Nama and Add	rass of Facility B			-	nd 21202	
	+	23a. Part1. Enter the disease, shock, or heart failure.	omplications that rause	ed the dear							Approximate Interval Between	
Physician /Medical Examiner		Immediata Causa (Finat diseasa or condition rasulting in death)	a AA	zrio	School as a consequence	til Ca	rd cs vos	surlar	Disa	ost	Onset and Death	
and Hransit	Examiner	Sequentially tist conditions,	b	Due to (or as a consequ	ence of):						
876(8 8	Sequentially tist conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a consequence of):								
			■ d							t		
death ce stending of for use	S F	Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death										
	by Physician/M							1 D Y	as 2 No	3 Prob	ably 4 Unknown	
	Completed							performed? available complet			ra autopsy findings ilable prior to apletion of cause eath?	
The lear	E							1 D Y	as Abrio	10	Yes 2□ No	
Vitai	0 2	25. Was case refarred to medical					26. Place of Dea	ath (Check only on	(9)			
	0	examiner? 1 XYes 2 No	Hospital: 1 _ tnpat	ient 2	ER/Outpatient	3□ DOA	ther: 4 Nursing h	loma 5 🕅 Raside	ence 6 Oth	er (Specify)	
On of Sing Phys After this funeral d		7. Manner of Death Natural 5 Pending	28a. Data of th		28b. Tima of Injury	28c. Inj	ury at ork?	28d. Describe ho	ow injury occur	red	- 34	
Attending and death.	ğ	2 ☐ Accident invastiga					☐ Yes 2 ☐ No				341	
Division s of Attending s effer death. In Director: Affer ad in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could no detarmin	ed 266. Place of I	njury - At h atc. (Speci	ome, ferm, streety)	et, factory, office	8	28f. Location (Si City or Town		oer or Rural	Routa Number,	
Hospit 24 hour Funer stely fill			Physician: To the bes aminer: On the besis and manner s	of axamina								
To the within To the comple		9b. Signature and title of certifier	1 ,				nse number		9d. Data signe			
	2	O. Name and address of person w	to completed cause of	Coult /Ite	n 23a) /Tuno D		C.M.E.		July 05	, 199	9	
		J-LARON	Locker 1	D	11		Street, B	altimore	, Maryl	and 2	1201	
State	e 3	1. Data filed (Month, Day, Year)	6 1000 Regis	tra s Sign	ature	9. De	acks					



AMENDED ITEM #5 PER FH G773 7/23/99 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JULY 4, 1999 William 4:10PM /Medical 4a Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RAVENWOOD LUTHERAN VILLAGE HAGERSTOWN WASHINGTON If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 M 2□ F Hours 237-50-3646 75 Director 08-30-1923 Pennsylvania Usual Residence of Decedent 10a, Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1K Yes 2 No Directo 28a-f Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 ne 23a 32 N. Patterson Park Ave. 21231 U.S.A. Funeral 12. Was Decedent Ever in U.S. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

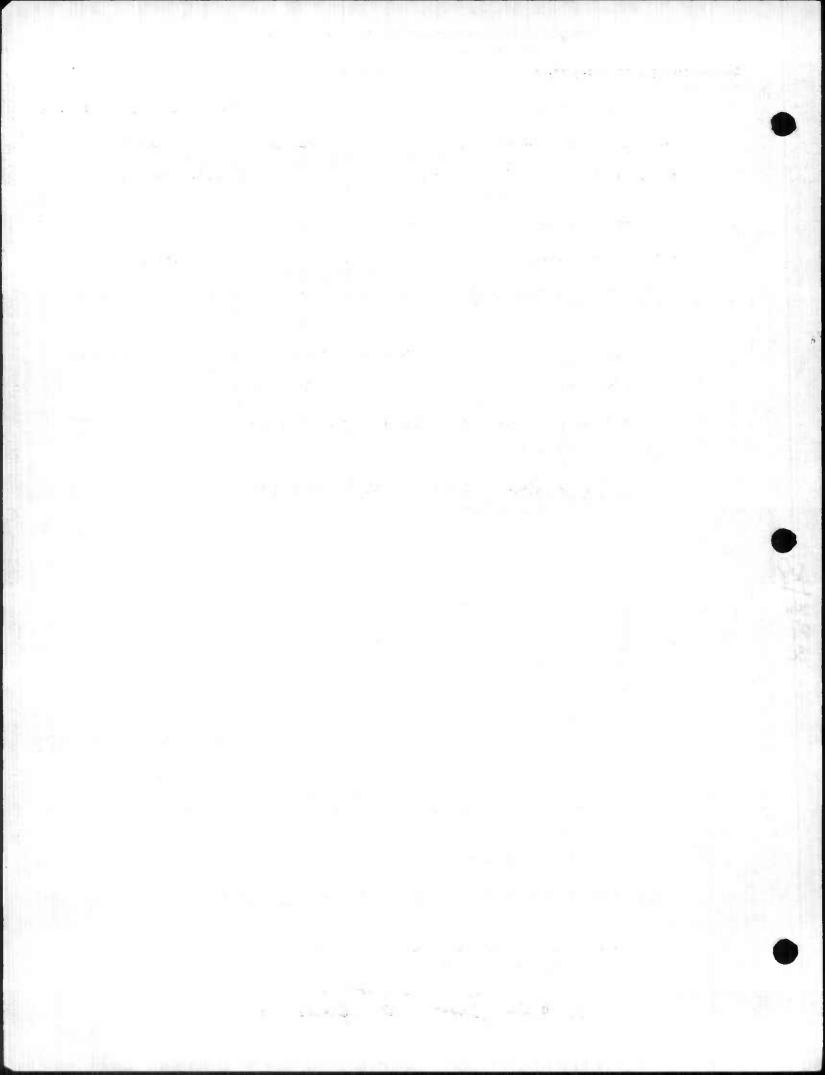
1 △ Yes 2 □ No
If Yes, Give
Yeer or Detes: WW II Black, White, etc. 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 8 1 Yes 2 No Specify: Specify: p, 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens, other then filed within Elementery/Secondery (0-12) College (1-4or 5+) 12 Years Accountant State Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Roland Gillen Christina Stunkard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Item 27 is other tra Thomas W. Dzur (Nephew) 17917 Golf View Dr. Hagerstown, Maryland 21740 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 14 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete = 5 Separtment 4 ☐ Donetion 5 ☐ Other (Specify) Maryland Vet. Cemetery 7/9/99 Garrison Forest MD 21. Signatura of Eunerel Service Licensee 22. Neme end Address of Facility Loring Byers Funeral Directors, Inc. J. Wayne Osterling 8728 Liberty Road Randallston the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, and fellure. List only one ceuse on each line. 8728 Liberty Road Randallstown, Maryland 21133 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical ACUTE BRONCHOPNEUMONIA 2 DAYS Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Physician/Medical the Due to (or es e consequence of): USB BS 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. o 3 1 Yes 2 No 3 Probably 4 Unknown DEMENTIA OF ALZHEIMER"S TYPE þ Records, 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed ARTERIOSCLEROTIC HEART DISEASE page 2 certificate has The 1 Yes 2 No 1 ☐ Yes 2 ☐ No Vital Attending Physician: funeral director, 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2√No this To 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? After 1 Netural Division 5 Pending 1 ☐ Yes 2 ☐ No death. investigetion 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29e. Certifier Medical (Check only one) To the Vithin 2 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D07857 JULY 8, 1999 30. Nama and address of person who completed cause of death (Item 23d) (Type, Print) DR. EDSON MOODY M.D., 1190 MT. AETNA ROAD, HAGERSTOWN, MD. 31. Date filed (Month, Dey, Year) 32. Registrer's Signetuje State Docks 9 1999 Registrar JUL **DHMH 16 Ray 6/95**

HMH 16 HAV 6/95



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	Amend	ed	Item#24a,27 perPhyG773	7/9/99 E					lealth a Death	nd M		g. No.	2	6	7 L;	
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	Physici /Medi		Mable M. Glessn	er							06		99	10:	15AM	
)	Examir		4e. Facility Neme (If not institution, gi	ve street and nu	mber)				4b. City, Tow	m, or Lo	cation of Deeth	4c. Count	y of Deeth			
			CAROLINE NURSIN	G HOME,	INC.				DENTO	N		CAR	OLINE			
	Funeral			Sex	7. Age (In yrs.	lest birthday)	If Unde	Devs	If Under 2 Hours	4 Hrs. Min.	8. Dete of Birth (Month, Dey,	Year)	9. Birthpl	aca (Sta	te or Foreign	
	Director		212-16-1416	1□M 2ÅF		92 Yrs.	IVIOLICIA	Deys	riours		Sept.9,	1906	PA	iy)		
	р.		Usuel Residence of Decedent													
	ehov det	_	10e. Stete 10b. County		10c. Ci	ity, Town or Lo	cation						10		e City Limits	
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	jt 4	Director	10e. Street and Number				10f. Z	p Code		10g. Citizen of What Country?						
	23a	ra	412-1 Liberty Ro					21632		U.S.A.						
	2 should be filed within 72 hours after death with the Meryland lend Mentel Hygiene. Is marked other than "natural", or items 23s or 28=4 show reumatic event, the Medical Examine must be notified at	Funeral	11. Maritel Stetus	Armed Fo		J,S. 13. \	Wes Dece f Yes, spi	edent of H	lispanic Origi en, Mexican,	In? (Spe Puerto l	cify Yes or No- Rican, etc.)		ca - America ck, White, e		١,	
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Maryland 21215-0020	hen hen lis n		19a. fnforment's Neme/Reletionship								Route Number,					
	s 1 and 2 should be filed within 72 hours after death with the Meryler I Health and Mentel Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examines must be notified at		Jaunita PAsswate 20e. Method of Disposition	rs/daugi		Pleca of Dispo		and the same of the same of	5, Br	ldge	ville, I		are 19933 n - City or Town, Stete			
jo	ges If He		1 ☐ Burial 2 ☐ Cremetion 3 (☐Removei from		cametery, cren	netory or	other plea	ce)	ì	Dete	oc. Location	- City or Tov	WII, Steti	,	
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Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signature of Funeral Service Lice	SAWare	Direc				ss of Fecility		, 655 W.	Rolt:	imoro	Ctr	oot	
ш	70 % a d		/ Whales	1/1/12	Mer			nore,		2120		. Dait.	rmore	SCI	eeL	
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	h. After funer	lon	27. Menner of Death 1 ☑ Neturel 5 ☐ Pending		ot Injury h, Dey Year)	28b. Time of Injury		28c. Injur Wor			28d. Describe ho	w injury occu	red			
Division	Attending r deeth. ector: Afte by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be	100			М		Yes 2□N		101 1 10 - 100 ·					
Ξ	after deet Director: J in by tha	E	4 ☐ Homicide determined	289. Pieca	of Injury - At h ng, etc. <i>(Specil</i>	ome, term, stri fy)	eet, fecto	ry, offica		2	28f. Location (Str City or Town	state)	oer or Hurai	Houle I	vum <i>ber</i> ,	
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		edical	29a. Certifier 1 ☐ Certifying PI (Check only one) 2 ☐ Medical Example (Check only one)	miner: On the ba	isis of examine	owledge, deeth etion end/or Inv	occurred estigetion	at the tin n, in my o	ne, dete end pinion, deeth	plece, e	and due to the ce ad et the time, de	use(s) end m te and plece,	enner es sta and due to	ated. the cau	se(s)	
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			Melle	_ 0	1/2m	RA) 5	16 39			6-1	2 16	1		
			30. Name and eddress of person who	completed caus	e of death (Iter	n 23e) (Type, I	Print)	n	1 5	1	1.17	0,0	/			
			31. Dete tiled (Month, Dey, Year)	riotte.	egistrar's Signer	ron	Me	the !	4 7	Jev	YOU! /	MX.				
	Sta Registr		Date that (mortal, Day, real)	9 1000	Sistem & Sign	2	9	door	K							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene WALTER GINDLESPERGER Amended Item#19b perFH G773 7/9/99 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Day **Physician** 1900 PM Walter Earl Gindlesperger, Jr. 5, 1999 JULY /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 10 BAYSIDE DRIVE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F 73 218.12.4135 Director Feb. 2, 1926 Pennsylvania Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show ahow Maryland 1 Ves 2 □ No Director Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ma 23a or 6 10 Bayside Drive 21222 U.S.A. Funerai filed within 72 hours efter deeth Nems 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Merital Status than "natural", or han Biack, White, etc. 112 Yes 2 No WWII
If Yes, Give
Year or Dates: 1 Never Married 2 Merried 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade comp 16b. Kind of Business/Industry Il Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Outside Machinist Maryland Drydock 7 is merked other treumstic event, Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Pages 1 and 2 should be in nent of Health and Mental Walter Earl Gindlesperger, Sr. Mary Myers 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) from 27 l Anna Gindlesperger/Wife 10 Bayside DRive Same as above 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State
4 Donation 5 Other (Specify) Department of Important: If any Injury or page. = 8 Baltimore Washington 17/10 Laurel, Maryland 22. Name and Address of Facility 21. Signature of Fonerel Service Licens Bradley-Ashton Funeral Home Utt) 2134 Willow Spring Rd. Balt., 21222 Md. Enter the disease or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Shotgun /Medical Immediate Cause (Final · Contact disease or condition resulting in death) Examiner Due to (or es a consequence of) Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical 94 Due to (or as a consequence of): 98 985 signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed Partial page 2 certificata 17 Yes 2 No 177Yes 2 No Division of Vital Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5XX Residence 6 Other (Specify) Certification: To XX Yes 2 No this 28a. Date of Injury FULL 128b. Time of (Month, Day Year) Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending subject efter death. self 1 Yes 2 No Sher investigation -5-99 18 48 2 Accident 3 Suicide 4 ☐ Homicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, Stete)
10 Busines Ac Orive Place of Injury - At hon building, etc. (Specify) At home, ferm, street, fectory, office filled in by Residence 6 within 24 hours e To the Funerel D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cabse(s) end menner es stated.

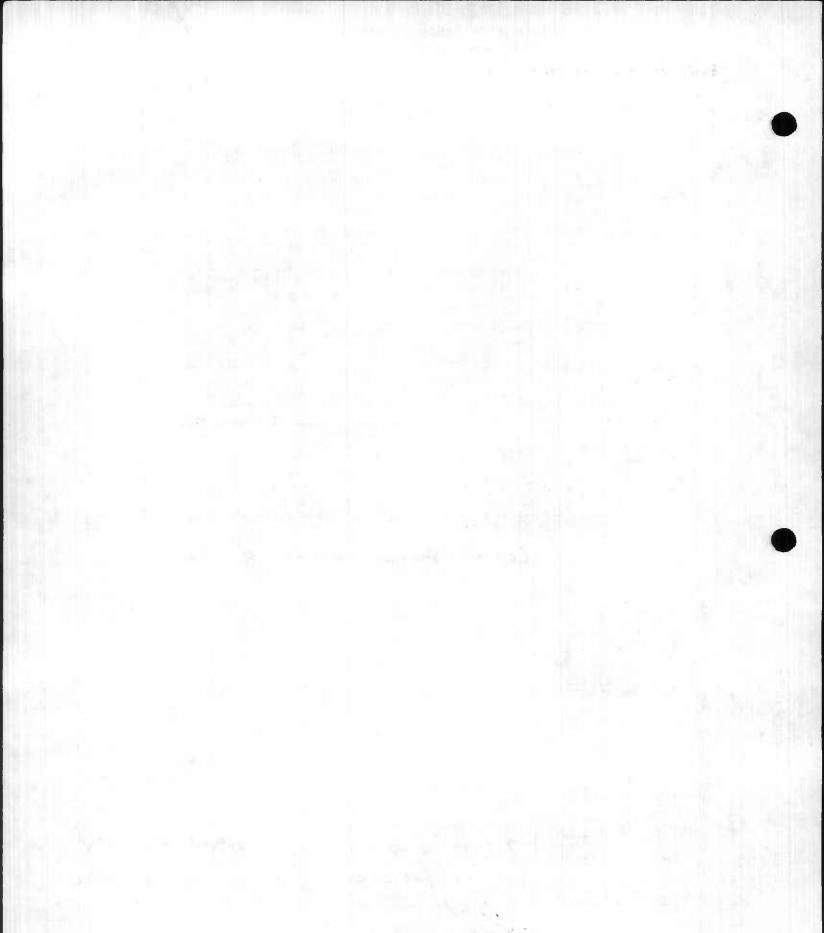
XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner states. 29a. Certifier edical completely (Check only one) \$ 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) JULY 6, 1999 O.C.M.E 30. Name and address of person who unhipleted cause of death (Item 23a) (Type, Print) Jav. A joy 65 111 Penn Street, Baltimore, Maryland 21201 32. Register's Signature 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

State

Registrar

JUL



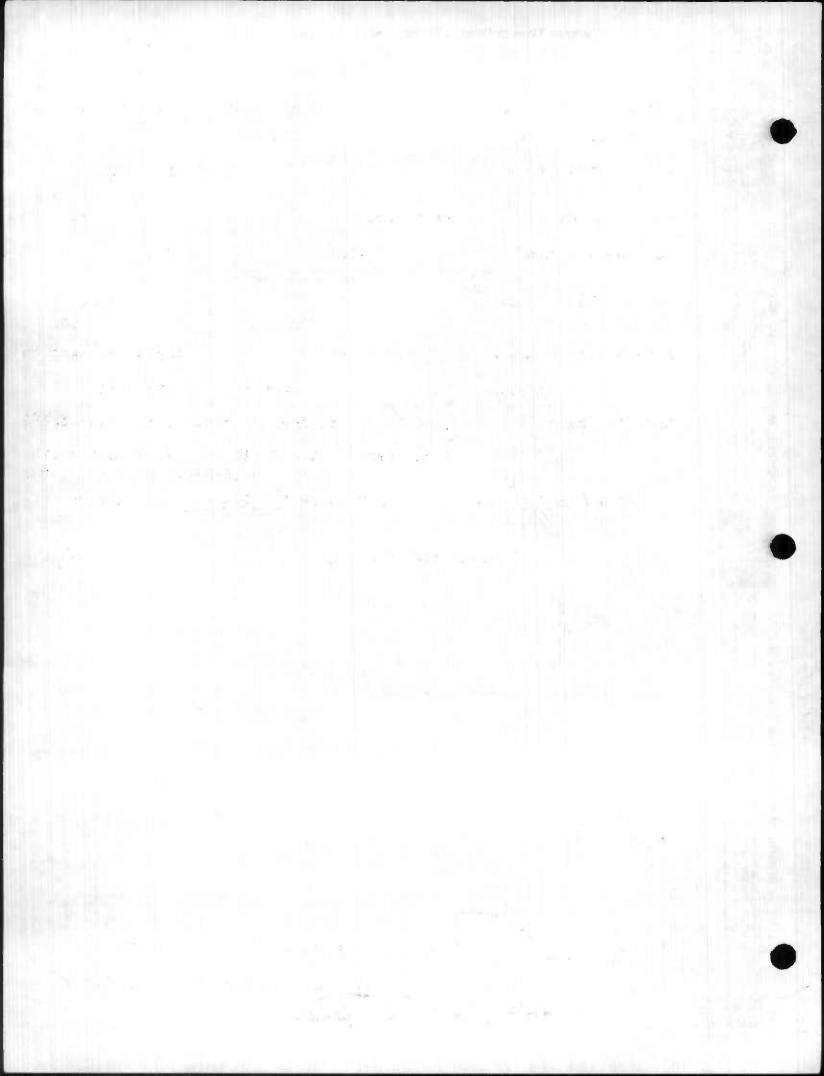
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** C. James 07, 99 Hammond July 11:30am /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 4634 Belair Road Baltimore NA 5 Social Security Number 8. Date of Birth (Month, Day, Year) 02-23-45 Birthpiece (State or Foreign Country)
 DC 7. Age (In vrs. last birthday) **Funeral** XIN M 2 F Months Days Hours 219-42-9684 54 Yrs. Director Usuai Residence of Deceden the Marylend 10a State 10c City Town or Location 10h Counts 10d. fnside City Limits 7 is marked other than "natural", or flems 23a or 28a-f show traumatic event, the Medical Examinar must be notified at XXYes 2□No MD NA Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 4634 Belair Road 21206 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Specify: Black altimore, Maryland 21215-0020 1 Yes 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry CO 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 11th Grade NA Ingram Excavation Truck Driver permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked othe any injury or other traumatic event, page. 17 Fether's Name (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Unknown Martha Hammond 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4634 Belair Road Baltimore, Maryland 21206 Mozella Hammond 20b. Piace of Disposition (Neme of 20a. Method of Disposition Date 20c. Location - City or Town, Stata cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Kings Mem.Pk. Cem 07-12-99 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerei Service Licensee 22, Name and Addrass of Facility Baltimore, Maryland 21202 emand WM.C.March FH 1101 E. North Avenue tommon 23a. Part 1. Enter the disease, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Deeth **Physician** /Medical fmmediata Cause (Final · Cancer of Larynx ZYR disaase or condition rasulting in death) Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) 98 Part II. Other signifficant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco usa contribute to the cause of death? signed by d be detect 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy Completed peen page 2 1□ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Attending Physician: 25. Was case referred to medical Be 26. Place of Deeth (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 27. Manner of Death 28c. Injury et Work? Certification: 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 X Natural il or Attending s efter deeth. il Director: Aff 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital To the Hospital within 24 hours e 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner as stated.
2 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier edicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier m D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3333 N. Calvert ST Balto, MO 21218

Calvert

32. Register's Signature

State Registrar 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** Elizabeth M. Hall July 6, 1999 6:30 PM /Medical 4a. Facility Name (If not institution, giva straat end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 221 Bay Front Road Pasadena Anne Arundel 7. Age (In yrs. lest birthday) 69 Yrs. If Under 1 5. Social Security Number If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) Birthplace (State or Foraign Country) **Funeral** 1 □ M 2 □XF Yrs. Director 578-44-3743 JAN 23, 1930 Ohio Usual Residence of Decadent 10a. State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits must be notified at MD Director Anne Arundel Pasadena 1 Yes 2 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ò items 23a 221 Bay Front Road 21122 USA 12. Was Decadent Ever In U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, filed within 72 hours efter Hygiene. other than "natural", or ite Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married þ 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed the Medical 15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse marked other Hospital 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Pages 1 end 2 should be I nent of Health and Mental I int: If Item 27 is marked of Dillon Seymour Myer Jenness Wirt 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) W. Luther Hall/husband 221 Bay Front Rd. Pasadena, MD 21122 permit. Pages 1 end Department of Health Important: if Item 27 any Injury or other to 20b. Placa of Disposition (Name of cametery, cremetory or other pleca) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/8/99 Metro Crematory, Inc. Baltimore, MD 21. Signature of Funeral Service Lip 22. Name and Address of Facility Cremation Society of Maryland, Inc. dwar Edward A Corchik 299 Frederick Rd. Balti 23e. Pertl. Enter the disease of compriseitons thet caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest shock, or heer feilure. List only one cause on each line. 299 Frederick Rd. Baltimore, MD 21228 Approximata Intervel Between Onsat and Death **Physician** Adaro carchong /Medical Immediate Ceuse (Final manho disease or condition resulting in deeth) **Examiner** Due to (or es e consequence of): Examiner burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in daath) Last Due to (or as a consequence of): Physician/Medical Due to (or as e consequance of): 88 use Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1√ Yes 2 No 3 Probably 4 Unknown should be d by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? page 2 1 ☐ Yes 2 W No 1 Tyes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Panding 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete) 3 Suicide 28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) lu by 4 Homicide edical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and dua to tha cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

The law requires that the death certificete be executed Box 68760. P.O. Records, Division of Vital or Attending Physicien: To the Hospital or Attan within 24 hours efter deet To the Funeral Director:

Baltimore, Maryland 21215-0020

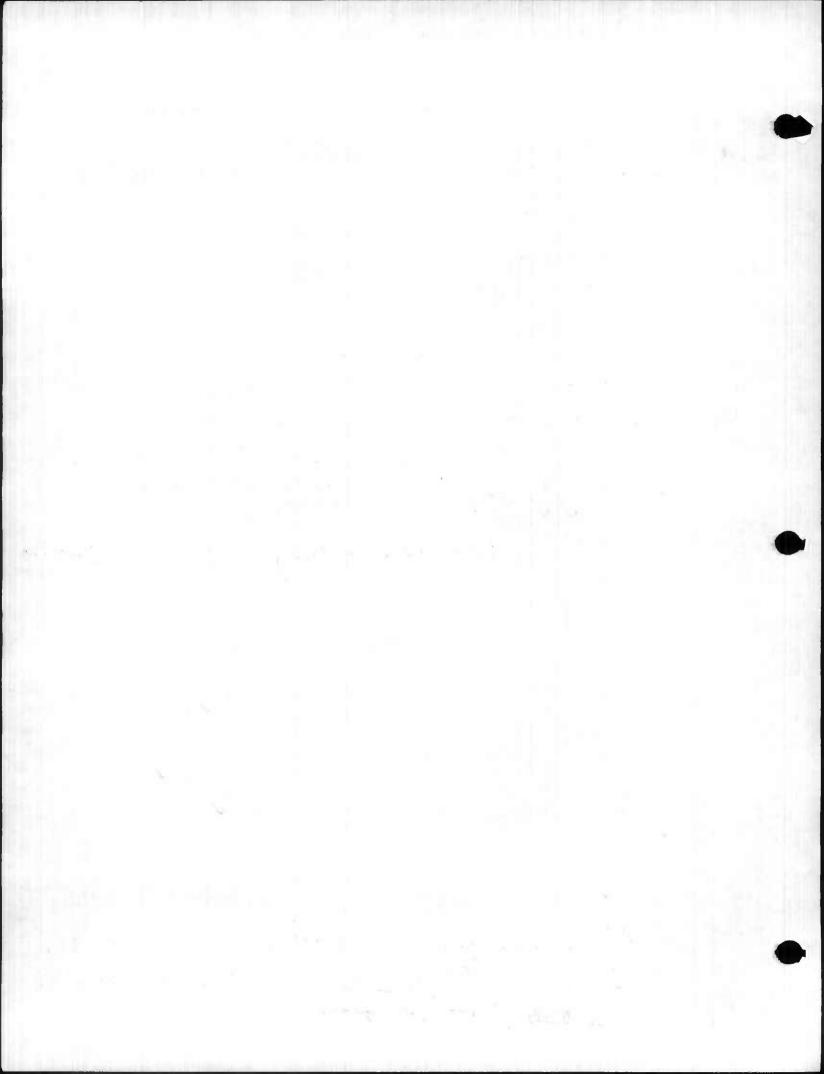
deeth.

State Registrar (Check only one)

29c. License number

29d. Date signed (Month, Day, Yeer)

Oah wood vord 6 len Bernie, Wel 21061 31. Date filed (Month, Dey, Year)



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene QQ Certificate of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month JULY 22:30 Margaret B. Hopkins 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, giva street and number) 4c. County of Death DALTIMORE ST AGNES HOSPITAL H Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JAN 18, 1935 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign 1 M AD F 579-46-3694 64 Yrs. Washington, DC Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yas 2 No Baltimore Catonsville 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Coda 2200 Tall Pines Court 21228 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Maritai Status 1 Nevar Married 2 Married 1 ☐ Yas 2 No Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highast grada completed) 18e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Eiementary/Secondary (0-12) College (1-4or 5+) Financial Analyst Federal Government 18. Mothar's Nema (First, Middle, Meidan Sumama) 17. Fathar's Nama (First, Middla, Last) James Brown Leora Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Denise V. Baugh/daughter 2200 Tall Pines Ct. Catonsville, MD 21228 20b. Place of Disposition (Nama of camatary, cremetory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Metro Crematory, Inc. 07/09/99 Baltimore, MD 4 Donation 5 Othar (Specify) 22 Care and Address of Factoriety of Maryland, Inc. MCDORALD 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or haert feilure. List only one ceuse on each line. Approximeta Interval Between Onset and Death Immadiata Causa (Final disaasa or condition resulting in death) PNEUMONITIS 4 MONTHS SYSTEMIC LUPUS ERYTHEMATODUS Dua to (or as a consequance of): Sequanticity list conditions, if any, laading to immediate ceusa. Enter Underlying Causa (Disaasa or Injury CONGESTIVE HEART FAILURE thet initieted events rasulting in daath) Last Pert II. Other significant conditions contributing to death but not rasulting in tha undarlying ceusa given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to complation of causa of death? 24e. Wes an autopsy performed? 1 Yas 2 NM 1 Yas 2 No 26. Place of Death (Check only ona) Hospital: Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Impatiant 2 ER/Outpetient 3 DOA 28b. Time of 28d. Dascribe how Injury occurred

Examine Physician/Medicai 950 þ

P.O. Box 68760,

Nopkins, Margaret

Physician

/Medical

Examiner

Physician

/Medical

Examiner

Directo

Funeral

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Funeral

Director

"naturel", or items 23s or adical Examiner must be

permit. Peges 1 and 2 should be filed within 72 hours after deeth v Department of Health and Meniel Hygiene. Important: If item 27 is marked other than "naturel", or items 23a any Injury or other traumatic avent, the Medical Examiner must page.

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25. Was cesa refarred to medical axeminar? 1 Yes 2 No 27. Mannar of Death 1 DNatural 2 Accidant

3 Suicida

4 Homicida

28a. Data of Injury (Month, Day Year) 5 Pending Investigation

6 Could not be determined 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

281. Location (Street and Number or Rural Routa Number, City or Town, Stata)

(Check only one) 29b. Signature and title of certifie

29d. Data signed (Month, Day, Year) JULY 07, 1999

30. Neme and eddress of person who completed ceuse of deeth (Item 23a) (Typa, Print)

AKSENTITEVICH

CATON AVENUE BALTIMORE 900

31. Data filed (Month, Day, Year)

32. Registrar's Signatura

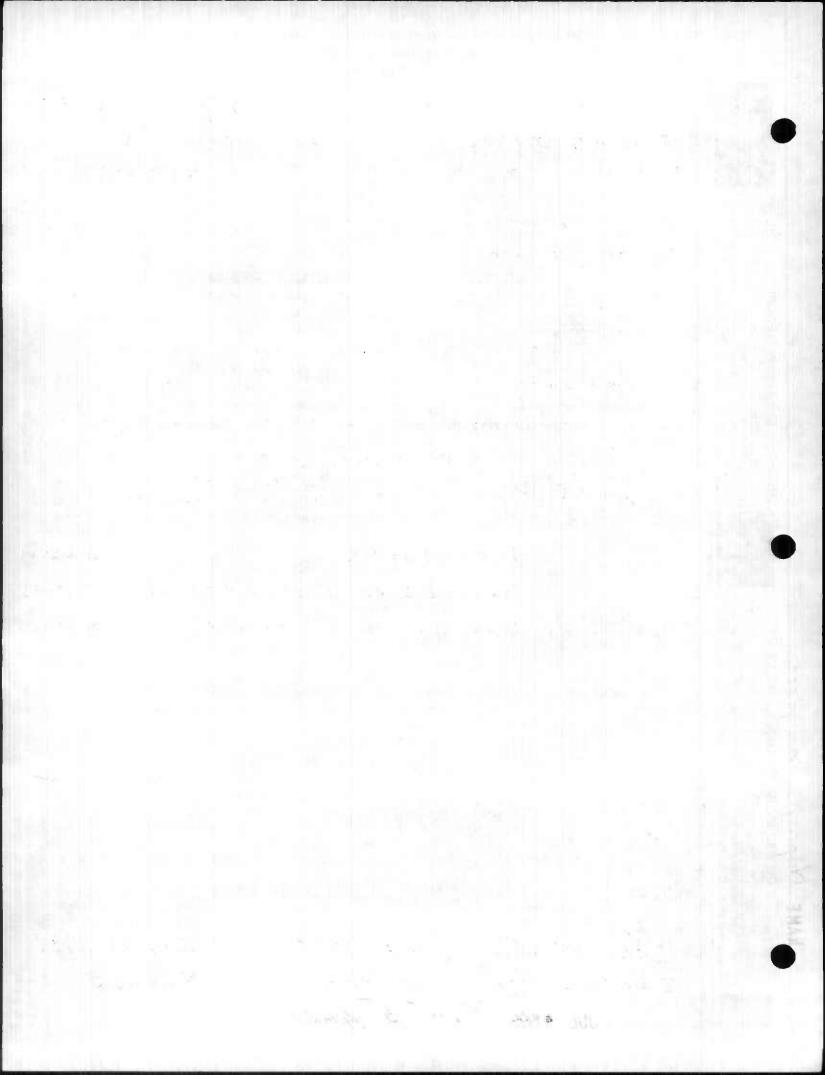
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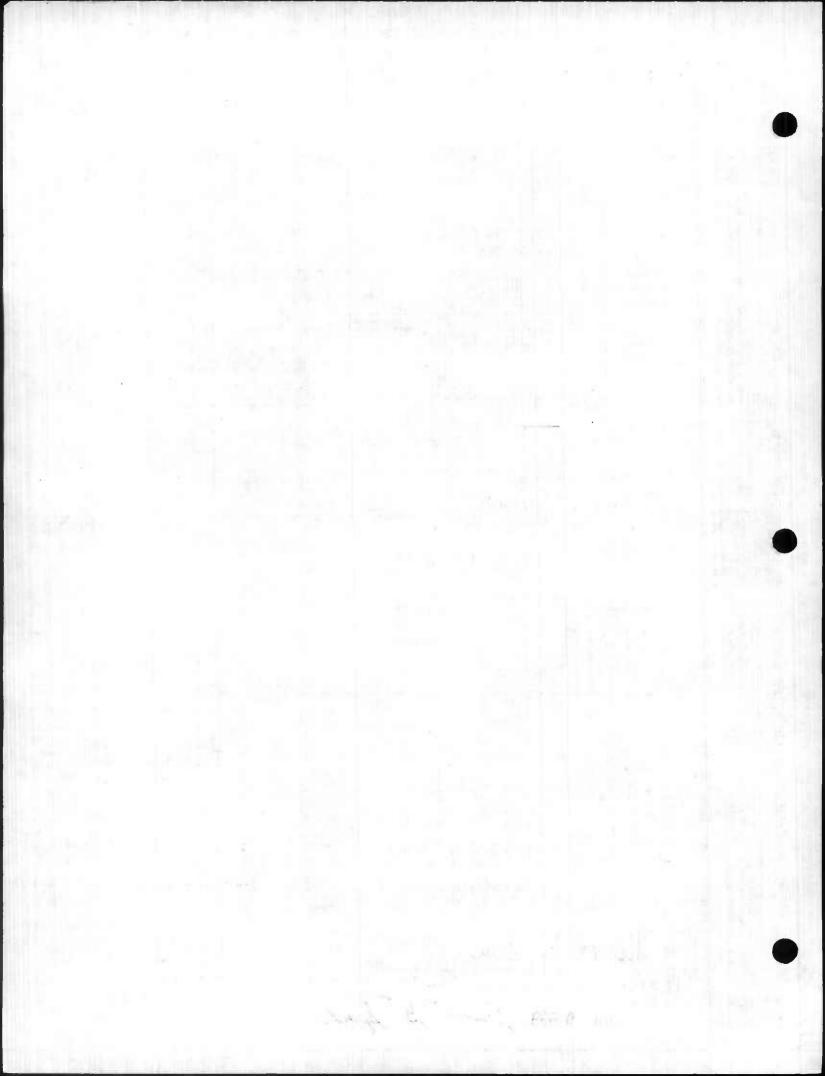
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	or oth	20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation	3 Removal from	n State	cemetery, cren	sition (Name of natory or other plac		6/30	20c. Location -				
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	the Hospital hin 24 hours the Funeral apletely filled		ng Physician: To the Examiner: On the and ma										
	within 24 To the Fu	29b. Signature and title of certific				29c. Licens	se number		29d. Date signe	ed (Month, Di	ay, Year)		
		o.c.M.E.							June 27, 1999				
	¥	30. Name and address of person	who completed car	use of death (Ite		Print) 111 Penn	Street,	Baltimo	re, Mary	land 2	21201		
	State Registrar	31. Dete filed (Mohth, Day, Year, JUL 0 9 199	Sene	Registrar's Sign	g. Sp	backs							

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Examin									Location of Deat	h 4c. County	of Death			
		JEFFERSON AND BROADWAY BALTIMORE N.7 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth												
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	ral Director	610 La		Road Apt	.#K		10f. Zip Code 2122			10g. Citizen of V USA	Vhat Country?			
	by Funeral	11. Marital Status 1 Never Man 3 Widowed	ried 2 Married	12. Was Decedent Armed Forces X (X) Yes 2 If Yes, Give Year or Dates:	? No		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 [7] No	Hispanic Origin? (S lban, Mexican, Puerl o <i>Specify:</i>	pecify Yes or No to Rican, etc.)		e - American Indian, k, White, etc. Black			
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Ore, illem		20a. Method of Dis	position		20b. F	lace of Dispo	sition (Name of		Date	20c. Location -	City or Town, State			
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Wade

Director

S.

death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21203-3146 BOX 13146, executed law requires that the death certificate be OF VITAL RECORDS, P.O.

HOSPITAL OR ATTENDING PHYSICIAN: The

TO THE FUNERAL DE Be filed within 72 h

BE

2

DIVISION

1 Vetural

2 Accident

3 Suicide

4 Homicide

by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 mnost.	ical examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECT
LUNERAL DIRECTOR: After this certificate has been signed by the artending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 2. DATE OF DEATH 1999 EAR 26 Robertson June 2:50 AM Joel Marguerite 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs, lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DAYS HOURS 11/12/23 D.C. 1 M 2 TF YRS 578-20-6963 9a. FACILITY NAME (If not institution, give atreet and number) 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF OEATH St. Mary's Nursing Center DIRECTOR Leonardtown St.Mary's 10b. COUNTY 10a. STATE 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Saint Marys Great Falls Mills 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? General Delivery 20634 20627 U.S.A. 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Maxican, Puerto Rican, etc.)
1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Married 2 Married Specify: white BY 3 X Widowed 4 Divorced COMPLETED 15. OECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) ost of working (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 6+) 12 unknown unknown Homemaker unknown Private unknown 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) William Margarite Marguerite Morrison 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Schrader/sister in law P.O. Box 31 General Delivery, Compton, MD 20627 METHOD OF DISPOSITION
Burial 2 Gremation 3 Removal from State 20b. PLACE OF DISPOSITION (Name of cometery, crematory or 20c. LOCATION - City or Town, State 4 Donation To Other (Specify) in state Gate of Heaven 7/14/99 Silver Springm, MD

21201 Baltimore, MD 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cardiec or respiratory errest, Approximata shock, or heart feliure. List only one cause on each line. interval Between Onset and Death IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMEO? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 | YES 2 | 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER 1 YES 2 NO raing Home 6 - Residence 6 - Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 27, MANNER OF DEATH 28d, DESCRIBE HOW INJURY OCCURED

22. NAME AND AODRESS OF FACILITY

State Anatomy Board, 655 W. Baltimore St.

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

1 ERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated. (Check only one)

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

1 YES 2 NO

History Co.			
N. SCHATURE AND TITLE OF CONTIFIER	LM	29c LICENSE NUMBER	294. DATE SIGNED (Month, Day, War)

. NAME AND	ADDRESS	OF PERSON	WHO CO	MPLETED CAUSE	OF DEAT	H (ITEM 2	(Type, Print	_
	()		1			17		

wid L Alkn 17817

31. DATE FILED (Month, Day, Year) 32. REGISTAR'S SIGNATURE 0 9 1999 Depera

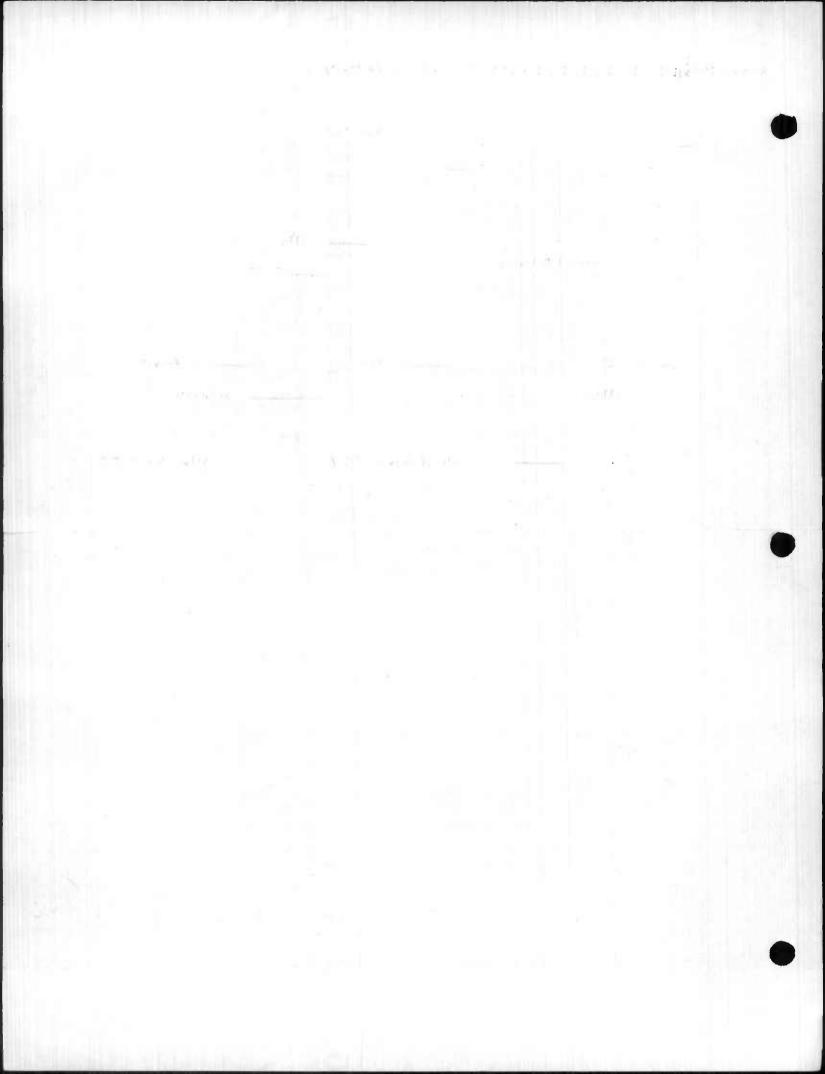
5 Pending investigation

6 Could not be

21. SIGNATURE OF FUNERAL SERVICE LICENSEE

Ronald

sout



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #10e PER FH G773 7/9/99 AH 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month **Physician** artha mes :OD P.M 1999 /Medical 4c. County of Peath 4a Facility Nama (II not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore N. ake Ave. A WOOD 8. Data of Birth (Month, Day, Year) If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (Stata or Foreign Country) **Funeral** Days Months 1 M 20 F Hours 216-16-2582 Director 192 Usual Residence of Decedant the Maryland 10a, Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits item 27 fa marked other than "natural", or itema 23a or 28a-f ahow other traumatic avent, the Medical Examinar must be notified at MD 1 PYas 2 No Baltimore Director 10a. Street and Numbar 10f. Zip Code 10g. Citizen of What Country? 627 N LAKEWOOD AVE 21213 5. A Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ᠿ No If Yas, Giva Yaar or Datas: 14. Race - American Indian, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Black, Whita, atc. permit. Pages 1 and 2 should be filled within 72 hours after to Department of Health and Mental Hygiena. Introctant: If flem 27 fa marked other than "natural", or than any injury or other traumatic avail. 1 ☐ Nevar Married 2 ☐ Married 1 Yas 200 No Baltimore, Maryland 21215-0020 Specify PV BLACK 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Cotlege (1-4or 5+) Elementery/Secondary (0-12) Johns PHINS HOSE enses aker NIA 18. Mother's Nama (First, Middle, Maiden Surname) 17. Father's Nama (First, Middle, Last) Be KoseHA Richard Homas mmons 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) aughter Balto. averne 62 20b. Place of Disposition (Nama of 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State Baltimore 4 ☐ Donation 5 ☐ Othar (Specify) Cemetery 22. Nama and Addrass of Facility 21 Signature of Funeral Service Licenses tho line 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intarval Batween Onset and Daath **Physician** /Medical immediate Cause (Final reare disaasa or condition resulting in deeth) Examiner Due to (or as a consequence of): sloian and burial-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician at the burial Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of). signed by the atte Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 1 Unknown 1 Yas 2 No þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen s has 2 1 No 2 No certificate 1 Yes funeral director, 25. Was casa referred to medical examinar? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 1 Yas 2 No 2 ER/Outpatient 3 DOA 1 Inpatient this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending invastigation To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 1 Yas 2 - No 2 Accident 6 Could not be detarmined 3 Suicide 28a. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pletely filled in by 4 Homicide edical 1 Certifying Physician: To tha best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar 29b. Signature and titla of certifier

31. Data filed (Month, Day, Year)

DHMH 16 Rav 6/95

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301

32. Registrar's Signatura

Name and addrass of parson who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

D43934

PLACE.

29d. Date signed (Month, Day, Year)

7/9/99

BALTIMORE, MO 21202

A C PAI T

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#5 PER F.H. G773 7-16-99 J.A. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Francis Harwood James, Jr. 1999 /Medical July 9:30 pm 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Nama (If not institution, give street and number) Examiner 796 Oak Lane Annapolis Anne Arundel If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 6 Sex Birthplece (State or Foreign Country) **Funeral** 212-90-0917 212-09-9017 1**X**0 M 2□ F Months Days Yrs Director 38 Feb. 5, 1961 Maryland Usual Residence of Decedant with the Maryland 10e State 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, ma Medical Examinar must be notified at 1 Yes 2 No Director Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 428 Forest Beach Road 21401 USA death 12. Was Decadent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. filed within 72 hours efter 1 ☐ Yes 2 ☑ No
If Yes, Give A
Yeer or Detes: 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 12 Waterman Seafood Peges 1 and 2 should be filed venent of Health and Mental Hygient: If itam 27 Is marked other in altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumama) Be Francis Harwood James, Sr. Nancy Ruth Wright 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Coda) Department of Health ar important: If item 27 Is any injury or other traconce. Wendy K. James (Wife) 9857 Bale Court, Owings Mills, MD 21117 20b. Placa of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/07/ Baltimore, MD 21. Signature of Funeral Service Licar 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 Do not enter the mode of dylng, such as cardiec or respiratory arrest, Approximete Interval Between Onsat and Daath **Physician** /Medical Immediata Cause (Finat disease or condition resulting in death) Examiner no carc The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last P.O. Box 68760. physician Physician/Medical the Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 90 24b. Were eutopsy findings available prior to completion of causa of death? Completed 24e. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No this certificate 1 Yes of Vital To the Hospital or Attending Physician: within 24 hours after death.

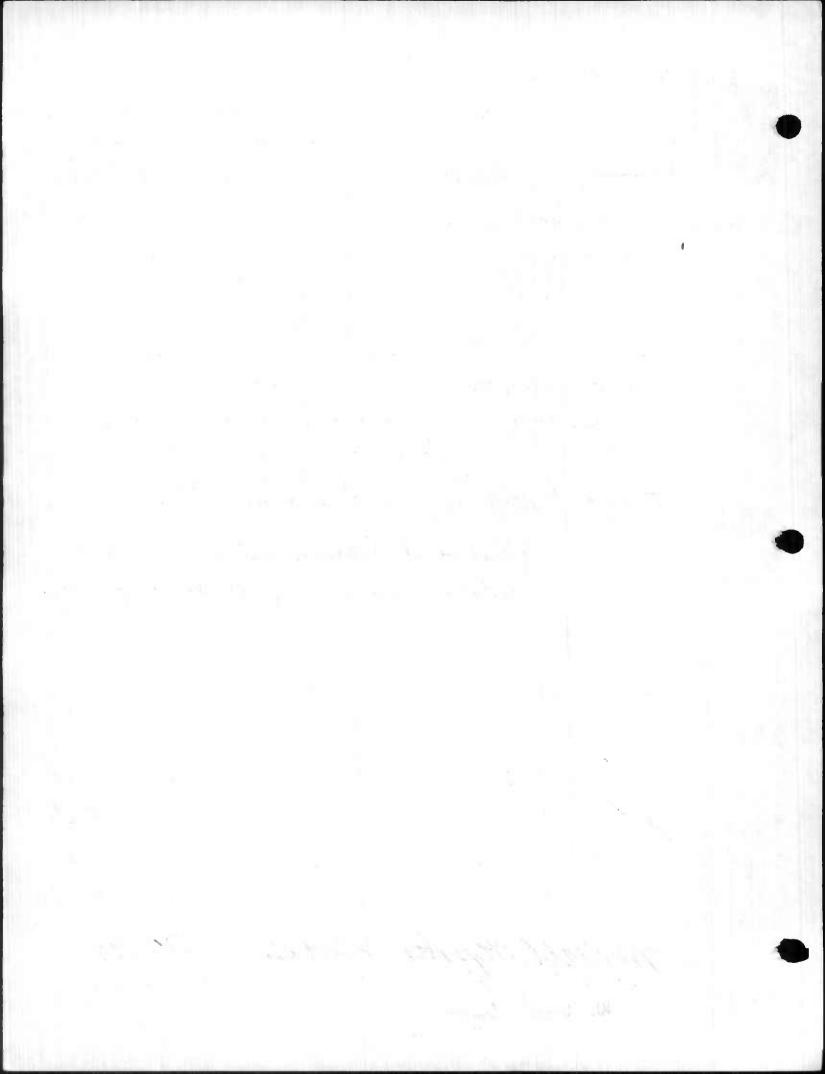
To the Funeral Director: After this certified 25. Wes case referred to medicat examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidance 6 Mothar (Specify) Friend's 2 1 ☐ Yes 20 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Manne of Death Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: Division 5 Pending invastigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident in by the 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signeture and title of certifier 29d. Data signad (Month, Day, Year) 29c. I Icensa number m 23e) (Type, Print) INNAPOLIS ve 32. Registrar's Signature 31. Date filed (Month, State

Registrar

DHMH 16 Rev 6/95

9 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 2. Date of Death

	1. Decedent's Name (First, Middle, Last)
Physician /Medical	Christopher Wil
Examiner	4a Facility Name (If not institution, give s
E Xamino	888 SOUTH BROADW

CHRISTOPHER JONES

Baltlmore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

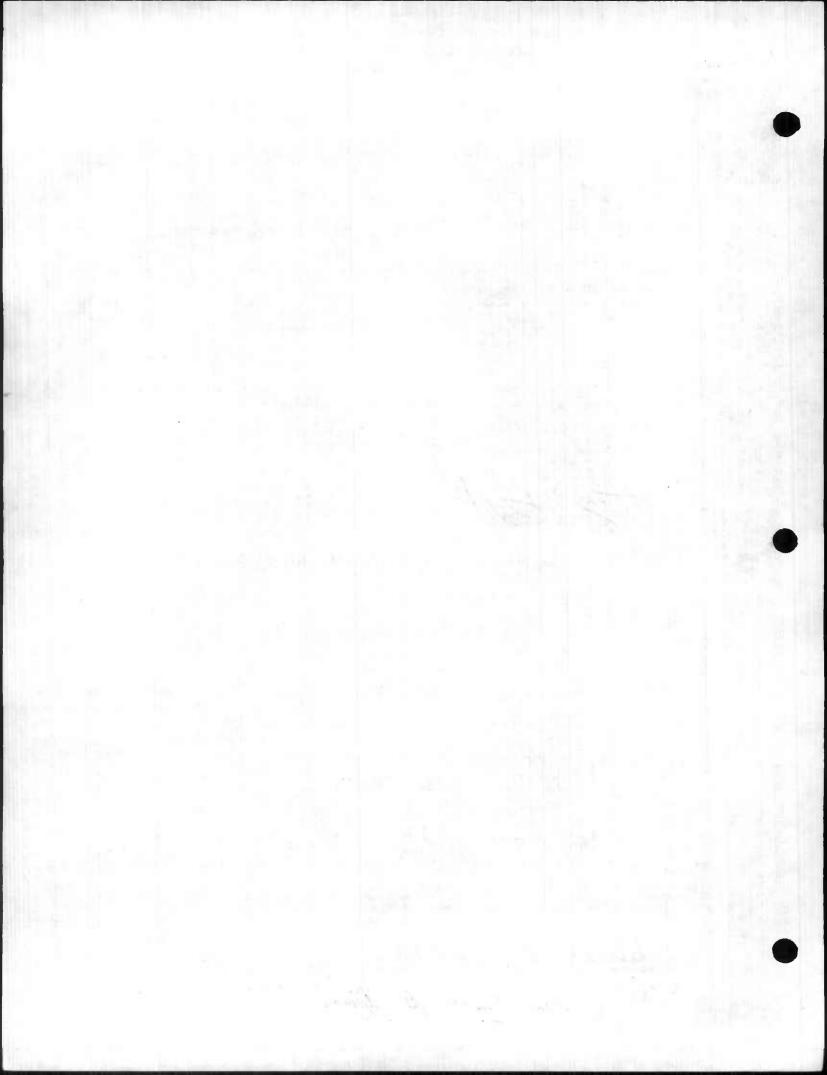
al	OULTSCOPHET MY	illiam Jones				JUNE	30, 19	99 1932 PM
er	4a Facility Name (If not institution, gi	ive street and number)			4b. City, Tow	m, or Location of Dea		
	888 SOUTH BROAD	DWAY		14.00	BALTI	MORE	N.	/A
		Sex 10 M 2 F 7. Age (In yr	rs. <i>last birthday)</i> Yrs.	Months Days		Min. (Month, E	irth (Nay, Year) 20,1961	9. Birthplace (State or Foreign Country) New York
	Usual Residence of Decedent	1						
_	10a. State 10b. County	10c. 6	City, Town or Lo	ocation				t 0d. Inside City Limits 1X Yes 2 □ No
Director	New Jersey Midd	dlesex Me	tuchen					120 Yes 2 No
Sire	10e. Street and Number							What Country?
	15 Voorhees			088	340		U.S	.A.
Funeral	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pt.					in? (Specify Yes or N. Puerto Rican, etc.)		e - American Indian, ck, White, etc.
þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🖔 No If Yes, Give Year or Dates:		1□ Yes 2Ñ No	Specify:		Specify	
Pe	15. Decedent's E		16a. Dece	dent's Usual Occi	pation	-442-	16b. Kind of B	usiness/Industry
Completed	(Specify only highest gr Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	life.	kind of work don DO NOT use retir	ed)	or working		
OT	, some je same je sa	4	Pr	oject N	lanager		Phari	maceutical
Be C	17. Father's Name (First, Middle, Las	et)			18. Mother	's Name (First, Middl	le, Maiden Suman	ne)
TOE	Howard William	n Jones			A	rlene Ad	ella Fa	rnham
	19a. Informant's Name/Relationship		19b. Maili	ng Address (Stree	et and Number	r or Rural Route Num	ber, City or Town,	State, Zip Code)
	Howard W. Jones	s / Father	1715	01d Pla	ink Rd	Milford	MI 4	8381
	20a. Method of Disposition	206	. Place of Dispo	osition (Name of matory or other pl		Date	7	City or Town, State
	12	ily) Hi	llside	Cemetery	7	7/7/99	Metucl	hen N.J.
	21. Signature of Funesti Service Lice	Bluk	22	2. Name and Add John C. 6415 I	Mille	r, Inc.	altimore	MD 21206
aminer	Immediate Cause (Finat disease or condition resulting in death)	ı b.	(or as a consec	quence of):	inj	uries		
al Examiner	disease or condition resulting in death) Sequentially list conditions, if any leading to immediate	Due to Due to	(or as a consec	quence of):	inj	uries		
	disease or condition resulting in death)	Due to Due to	(or as a consec	quence of):	<u>inj</u>	uries		
sician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to C. Due to	(or as a consec	quence of):			d tobacco use co	entributa to the cause of death
Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to C. Due to	(or as a consec	quence of):		23b. Di	d tobecco use co □ Yes 2 2 No	entributa to the cause of death
by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to C. Due to	(or as a consec	quence of):		23b. Di 1[
by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to C. Due to	(or as a consec	quence of):		23b. Di 1[24a. Wa per	Yes 22No	3 Probably 4 Unknow 24b. Were autopsy findings available prior to completion of cause
e completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions of the con	Due to C. Due to	(or as a consec	quence of):	iven in Part I.	23b. Di 1[24a. Wa per	Yes 2 No as an autopsy formed? Yes 2 No	3 Probably 4 Unknow 24b. Were autopsy findings available prior to completion of cause of death?
o Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions of the conditions of the conditions of the cause of the	Due to C	(or as a consec	quence of): quence of): inderlying cause g	iven in Part I.	23b. Di 1 [24a. Wa per 1/2 of Death (Check only	yes 2 No as an autopsy atomed? Yes 2 No y one)	3 Probably 4 Unknow 24b. Were autopsy findings available prior to completion of cause of death?
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Certification: To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions of the con	Due to C. Due to Due to	Cor as a consect (or as	quence of): quence of): quence of): anderlying cause of the cocurred at the	26. Place ther: 4 Nur ury at ork? Yes 2 1	23b. Did 1 [24a. Wa per 12 of Death (Check only) sing Homa 5 Re 28d. Describ 5 ubje 28f. Location City or 7 Baltin I place, and due to th	as an autopsy flormed? Tyes 2 No rone) sidence 8 Ott se how injury occur c t Struc blun t (Street and Num) own, State) 9 8	3 Probably 4 Unknow 24b. Were autopsy findings available prior to completion of cause of death? 12(ves 2 No Ner (Specify) AT SCENE Tred on head with the per of Aural Route Number, 88 S. Broad way 4 y. Manylandanner as stated.
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State Registrar Strphen S. R. 31. Date filed (Month, Day, Year) 9 1999

Radentz

DHMH 16 Rev 6/95

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2 Date of Death Month CARL W 06 1999 100 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Washington Adventist Hospital Takoma Park Montgomery If Undar 1 Yaar | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 1⊠M 2□ F Days 83 YES 181-03-5524 Aug. 16, 1914 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Takoma Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7710 Maple Avenue 20912 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Contractor Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Kirk Elizabeth Lake 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Kirk/spouse 7710 Maple Avenue, Takoma Park, MD 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licensaa 22. Name and Address of Facility Wade Director State Anatomy Board, Baltimore, MD 21201 Ronald S 655 W. Baltimore Street Baltimore, MD 212U1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximata Intarval Between Onset and Death SHOCK SEPA16 Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 6 HOM THU BUERMONT Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Last STROKE CEREBRAL Dua to (or as a consequence of): RO SCEERO TIL HEART DUSEATE Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? lasuffic Ency 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to ALBUNEMIA 24a. Wes en autopsy complation of cause of death? 2 750 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending invastigation 1 Tyes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

Physician/Medical 98 signed by to by Completed

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Examiner

Physician

/Medical

Funeral

Director

itam 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avent, the Medical Examiner must be notified at

permit. Peges 1 and 2 sh Depertment of Health and fmportant: If Itam 27 is m any injury or other traun pncs.

Physician

/Medical

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Division of Vital Records, P.O. Box 68760.

2 should be filed within 72 hours efter death v and Mental Hygiena. Is marked other than "natural" or harms 22°

Saltimore, Maryland 21215-0020

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Examiner

Directo

Funeral

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Completed

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7,	Menner of	Death		

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

4 - Homloide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier

29c, License number

29d. Data signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) & ROCC

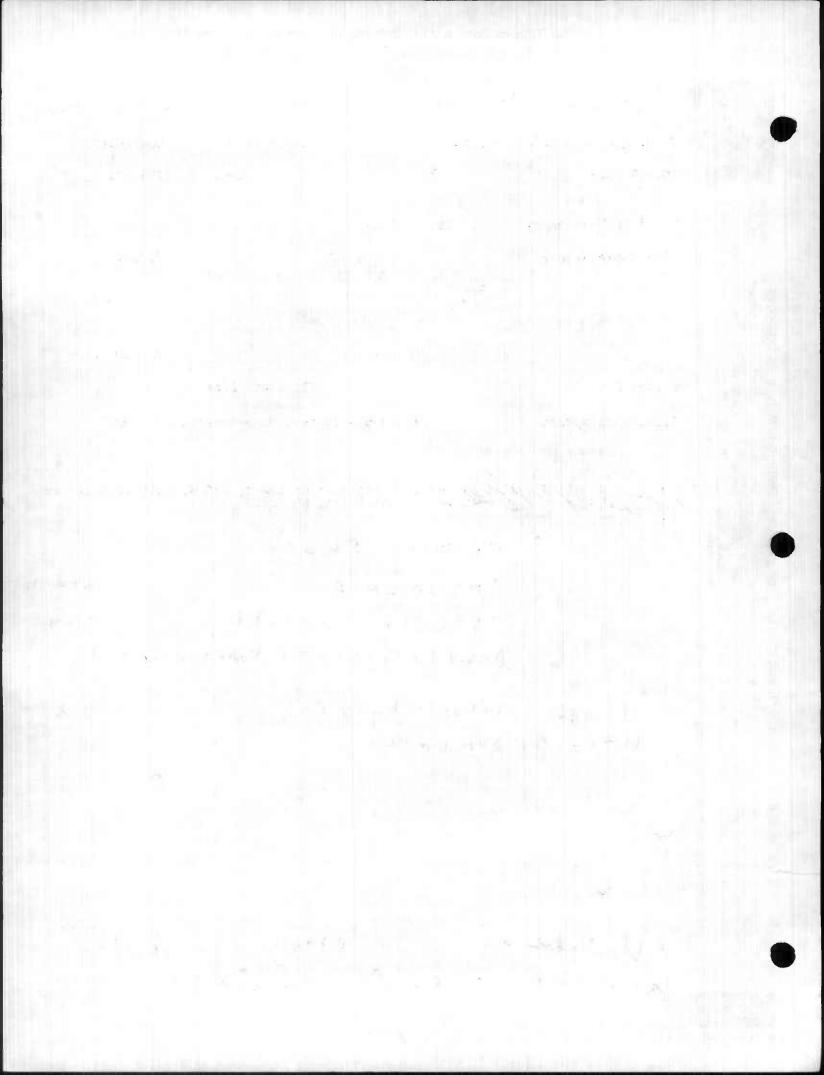
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. SudHAKAR. mo 31. Date filed (Month, Day, Year) State

7610 32. Registrar's Signature

Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6年 8-30 Pm Robert Edwin Kline Sr. July 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital Westmenten Carnoll Country General Courroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (Irl yrs. last birthday) **Funeral** 214-28-6118 1⊕M 2□ F 67 Nov. Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Directo Maryland Carroll Manchester 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examples must be 3118 Ferrier Rd. 21102 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Tool Grinder permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien Important: If Item 27 is marked other that any Injury or other treatment. Ward Machinery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Marquerite Bupp UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3118 Ferrier Rd. Manchester, Md. 21102 Ella Mae Kline - wife altimore. 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State New Lutheran Cem. July 9,1999 Manchester, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel Starth 3296 Charmil Dr. Manchester, Md. 21102 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer feiture. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). physician a Box 68760. pulmonalae edical Due to (or as a consequence of): Physician/M 23b. Did tobacco use contribute to the cause of death? Part II. Other algorithms conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t d be detach 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peed 1 ☐ Yes 2 No 1 ☐ Yes 2 M No certificate Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 124 hours after d the Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D51596 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carroll Granty General Hospital, 200 Memoral Avenue, West-monister. K. Ambalavanar 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

DHMH 16 Rev 6/95

JUL 9 1999

2. Registrar's Signature
4. Aparts

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** July 6, 1999 Stella Mihal Kurz 1:30 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Towson If Under 24 Hrs. Manor Care Ruxton Baltimore County If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 1□ M 2♥F Months Deys Hours Yrs. Director 98 213-16-6750 June 6, 1901 Austria Usual Residence of Deceden the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 25s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore County Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3202 Woodside Avenue 21234 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. e filed within 72 hours after of Hyglens. or Her other than "natural", or Her 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Saitimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: specify: White þ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Own Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fill h and Mental H is marked oth Be Andreas Mihal Unknown 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Heelth and Important: If Itam 27 ia m any Injury or other traum DDCs. 20b. Place of Disposition (Name of cametery, cremetory or other place)

Baltimore, MD 21234

Date 20c. Location - City or Town, State Margaret A. Schock (P.R.)
20e. Method of Disposition 1 X Burial 2 Cremation 3 Removel from Stete 4 Donetion 5 □Other (Specify) 7/8/99 New Cathedral Cemetery Baltimore, Maryland 21. Signature of Funeral Service County 22. Name end Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. Mules Xewson Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Strope Months Examiner Due to (or as a consequence of): Examin attending physician and for use as the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. an/Medical Due to (or as a consequence of) Physici P.0 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 9 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes en autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending P1
 24 hours after daeth.
 Funeral Director: After the Certification: 5 Pending Injury 1 SeNatural 1 Yes 2 No investigation 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Complately filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 1-12849 7-6-99 Edm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 16 Rev 6/95

State

Registrar

A. H. Ghiladi

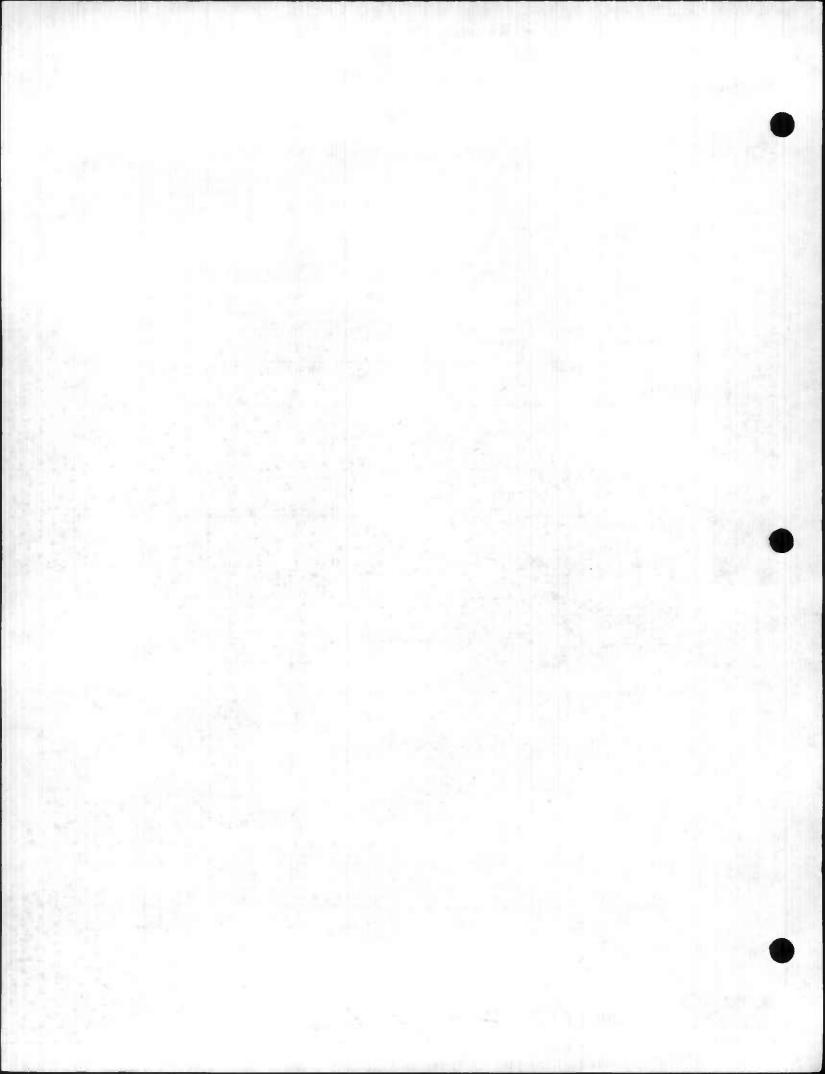
31. Date filed (Month, Day, Year)

M.D.

JUL 0 9 1999

32. Registrer's Signature

7600 Osler Drive, Suite 111, Towson, MD 21204



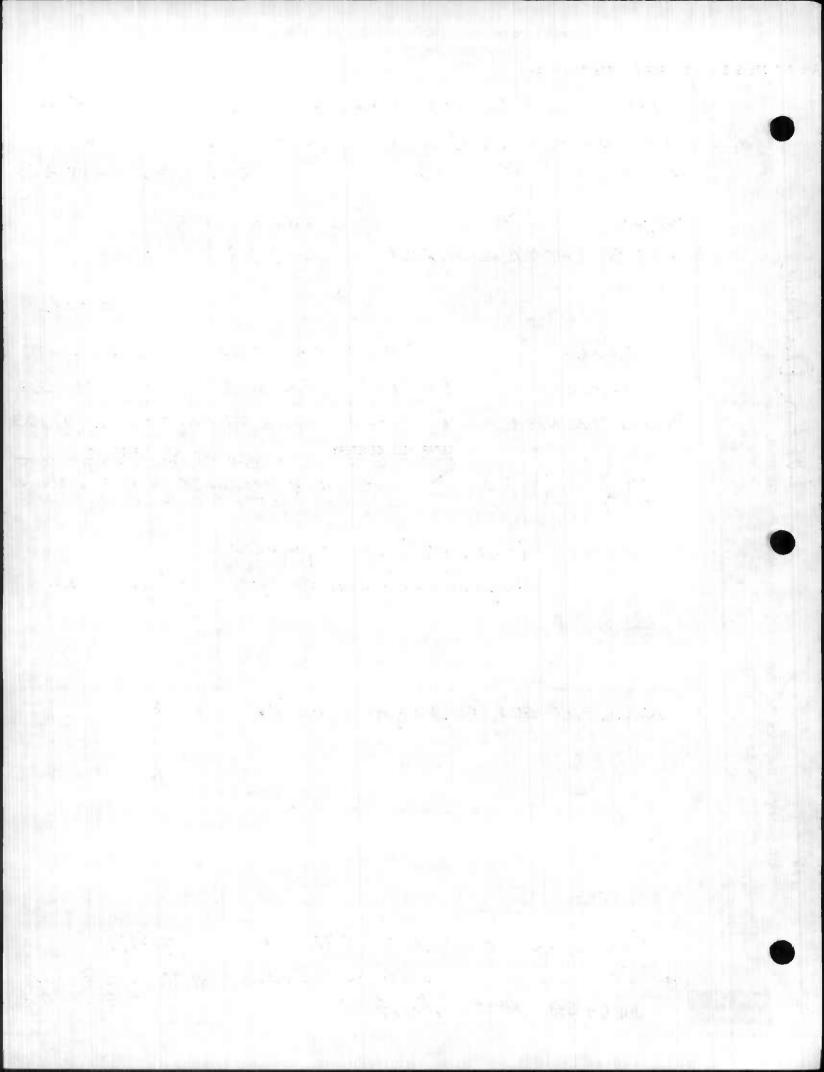
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q AMENDED ITEMS 20b & 20c PER FH G773 7/9/99 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1520 LOFTON Juli AR LENE /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** BALTIMORE
If Under 24 Hrs. 8. Date of CENTER EATON MEDICAL if Under 1 Yeer 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1□M 2XF Months Deys Hours 215-78-506. Usual Residence of Decedent JULY 26, 1958 Director 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Meryler r 28a-f ehow 1 Yes 2 □ No Directo MARYLAND 10e. Street and Number log. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a ATHERINE STREET Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Rece - American Indian, Black, White, etc. 14. Rece -11. Maritel Stetus ton Parleno 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) end Mental Hygiene. 12+#GRADE MANAGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 end 2 should be FREDDIE BOWLES EATHER MAE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) if of Heelth 1315. CATHERINE ST., BALTIHORE, MD. 21223
e of Disposition (Name of Date 20c. Locetion - City or Town, State FREDDIE MAE NASH (MOTHER) 20b. Place of Disposition (Name of cametery, crematory or other place)
DAR HILL CEMETERY 20a. Method of Disposition

1 Burlal 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) 22. Name and Address of Fac 21. Signature of Fundral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. FUNERAL 2121 Physician /Medical immediate Cause (Final disease or condition resulting in death) **Examiner** Examiner physician end the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Records, P.O. Box 68760, certificate be Physiclan/Medical Due to (or as a consequence of) 80 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Recurrent oral & esophagea 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 1 Yes 1 ☐ Yes 2 ☐ No Division of Vitai Be 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To After this 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 24 hours after death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end manner stated. 29a. Certifier Medical (Check only one) within 2 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier, eletandu MD 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) DEATON SPECIALTY HOSP, 611 S. Charles St. Balt, 31. Date filed (Month, Day, Year) 32. Registrar's Signatur 21230 md. State 0 9 1999

DHMH 16 Rav 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month PPM **Physician** William 0 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Regional Hospital Prince George's -aurel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Months DOM 20 F 211-05-5728 Yrs. 83 June 7, MD Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumstic event, the Modical Examiner must be not fed at MD Prince Georges Laurel 1 Yas 2 No Directo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? with United States 20724 3389 Horsehead South Pages 1 and 2 should be filed within 72 hours after death nent of Heelih and Mental Hygiene.

Instit if item 27 is marked other than "naturel", or items 23, mit: if item of 21 is marked other than "naturel", or items 23, may or other traumatic event, the Medical Examine must my or other traumatic event, the Medical Examine must Funeral 12. Was Dacedant Ever In U.S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, Whita, etc. TXMes 2 No If Yes, Give Yaar or Dates: Unk. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White Specify þ 3℃Vidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) Security Officer Johns Hopkins Hosp. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nettie Gawn Ross M. Lewis 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AAFE - EUR REGION APOAE Donna Winz Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Date Department of important: If it eny injury or o 1 ☐ Buriai 2 ☐ Cremation 3 📆 Ramoval from State 1999 Sand Hill Cem. 10, Sand Hill, July 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Sarvice Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 Fast Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medicai mongy. Examiner Due to (or as e come Examine (grafiun physiclan end the buriel-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieled events resulting In death) Last Division of Vital Records, P.O. Box 68760, 161 Physician/Medical 98 950 deteched Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Inknown signed t by 24b. Ware eutopsy findings availabla prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed certificate has b 1 Yes 2 DING 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes cese referred to medical examiner? Be 26. Piace of Death (Check only one) Hospital: To Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Deeth 28d. Describe how injury occurred Certification: 28h Time of 28c. Injury at Work? After 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident ofter deet Director: 6 Could not be 3 Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) a Funeral Director Selection Control of Funeral Director Selection Control of Selection Contr 4 Homicide 29a. Certifier 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated. edical To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatury 29c. Licensa number 29d. Date signed (Month, Dey, Year)

State Registrar

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31. Date filed (Month, Day, Yeer)

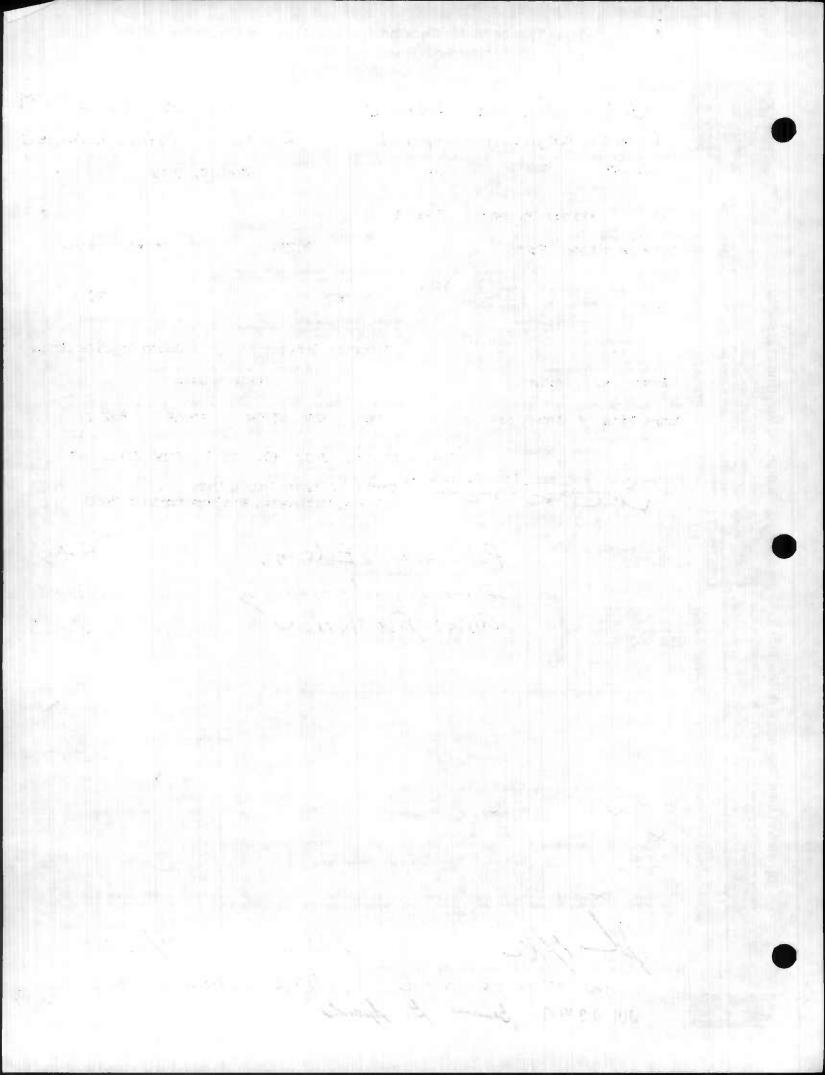
30. Name and address of person was completed ceuse of death (Item 23e) (Type, Print)

MAR 6-0CIS MD

32, Registrer's Signeture G.

Sports Baltimore

2070)



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State of Maryland

/ Department of Health and Mental	Hygiene	Q	0	2	1	-	0	6
Certificate of Death	Reg. No.)	2	2		0	7	1

2. Dete of Deeth

Day

Year

1999

4c. County of Death City

10g. Citizen of What Country?

U.S.A.

t4. Race - American Indian Black, White, etc.

Specify: Asian

16b. Kind of Business/Industry

Month

Phy	sician
/M	ledical
Exa	miner

1. Decedent's Name (First, Middle, Last) Kimdang Thi Le 4a Fecility Name (If not institution, give street and number)

Never Married 2 Married

3 Widowed 4 Divorced

JOHNS HOPKINS HOSPITAL

10007 Woodkey Lane

15. Decedent's Education (Specify only highest grade completed)

JULY 4b. City. Town, or Location of Death

3. Time of Death 7:45P.M.

10d. Inside City Limits

1 Yes 2 No

21117

3 Probably 4 Unknown

24b. Were autopsy findings available prior to

completion of cause of death?

Funeral

220-53-6399 Usual Residence of Decedent 10a. State 10b. County Md.

5. Social Security Number

1 M 2 DyF Yes 10c. City, Town or Location Owings Mills Baltimore

12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates:

7. Age (In yrs. last birthday)

#9

If Under 1 Year Months

10f. Zip Code

21117

1 Yes 2 No Specify:

Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

8. Date of Birth Feb. 11, 1999

9. Birthplace (State or Foreign Baltimore

Director

the Manyland ral", or items 23s or 28s-f show Exemples must be notified at

Director Funeral þ Completed Be 2

10e. Street and Number 11. Merital Status

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or her any injury or other traumatic avent, the Medical Exerciti

altimore, Maryland 21215-0020

Physician /Medical Examiner

The law requires that the death certificate be assocuted P.O. Box 68760, been signed by the a should be detached t Records, page 2 Division of Vital or Attending Physician: funeral director, this Affer

Examiner Physician/Medical þ Completed Be Certification: To 24 hours after death. filled in by Hospital Medical within 2 To the ş

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Danh ngoc Tu Kimdung Thi Le 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danh Ngoe Tu 10007 Woodkey Lane #9 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 11, 1999 Baltimore, Md. Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Fungital Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel Do not enter the mode of dying, such as cardiac or respiretory arrest,

Approximate 23a. Part1. Enter the disease, or complications that caused the death. shock, or hear tailure. List only one ceuse on each line. Immediate Cause (Finat disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of): Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? No No 1 Yes 24a. Was an autopsy performed? 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No T Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 26e. Place of Injury - At hom building, etc. (Specify) At home, farm, street, factory, office Momicide 29a. Certifier (Check only 29c. License number 29b. Signati O.C.M.E. JULY 8, 1999

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the ceuse(s) and manner stated.

29d. Date signed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

DCFC) WO
32. Registrar's Signature ALON

111 Penn Street, Baltimore, Maryland 21201

State Registrar

DHMH 16 Rev 6/95

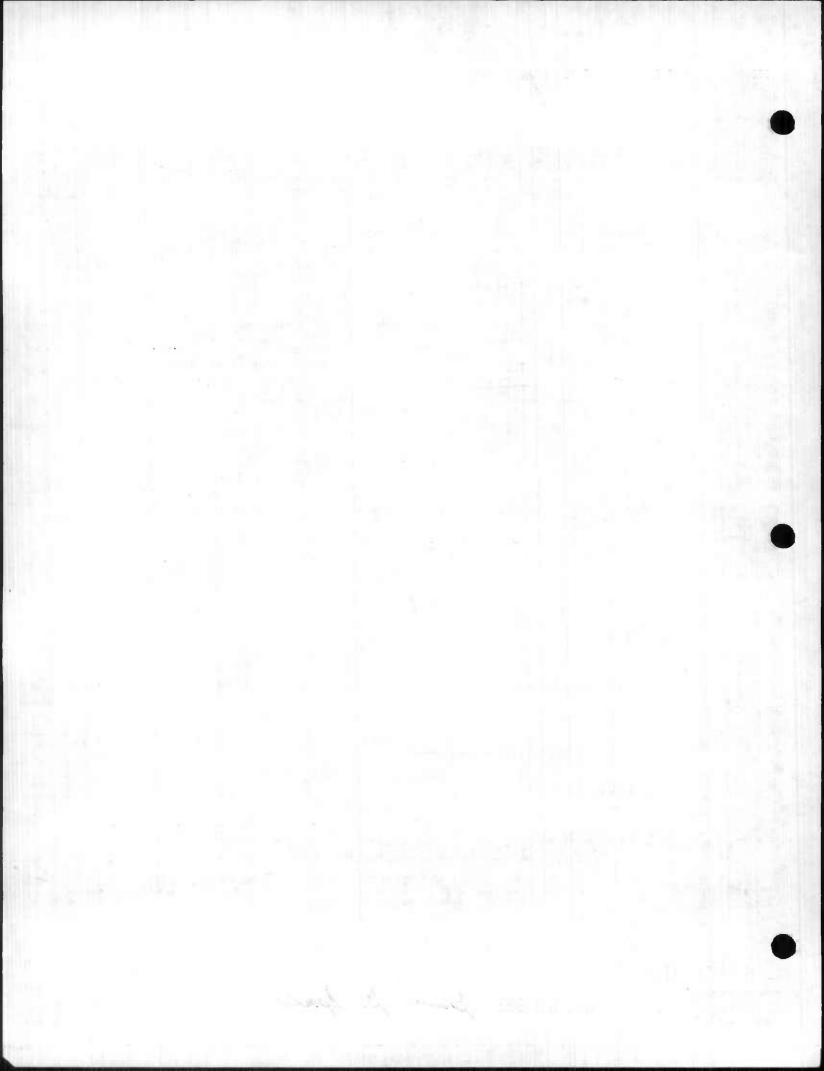
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31. Date filed (Month, Day, Year)

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was to full



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Deeth Month **Physician** JULY 4, 1999 WILLIAM THOMAS LATVANAS 2:00 AM /Medical 4a. Facility Name (If not Institution, give streat end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore #Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) 1. 19 1048 Cooks Lane 5. Social Security Number If Undar 1 Year 7. Age (In yrs. lest birthdey) 6 Sax Birthplace (State or Foreign Country) Funerai 1**X**□M 2□F Months Days Yrs Director Balto., Md. 216-16-9206 Usual Residence of Decedent Sept. 4, 1923 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at ₩ Yas 2 No Directo City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Herns 23a Funeral 1048 Cooks Lane 21229 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? 1€X'es 2 □ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, Whita, etc. 1 Never Marriad 2 Married ò 1 ☐ Yes 2√ No Specify: White by 3 Widowed 4 Divorcad natural W.W.II Completed 16a. Decedent's Usual Occupation (Give kind of work done duning most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest greda completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) other t Cement Mason Construction 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Mental th and Mental traumetic Jospeh Latvanas Elizabeth Boronos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 Department of Health a Important: If Item 27 is any injury or other tra 1048 Cooks Lane Baltimore, MD 21229 Anna M. Latvanas (wife) 20a. Method of Disposition 20b. Place of Disposition (Neme of cematary, cremetory or other piece) Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD. VET. CEM., Crownsville 7-7-99 Crownsville, MD MI Service Lioennee 22. Name and Address of Facility 4107 Wilkens AVenue HUBBARD Funeral Home Baltimore, MD 21229 Balti plication, that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, one ceuse on each line. Approximate Interval Between Onsat and Death **Physician** VAMOUS CEll CARCINOMA OF LARYNX Immediate Ceuse (Finel disaasa or condition resulting in death) Examiner Examiner Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseasa or Injury that Initiated events resulting in death) Lest Due to (or as a consequence of): end ettending physician Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No signed by 3 Probably 4 Unknown hronic Obstructive Lung Disease by Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy RECURRENT PHEUMONITIS completion of cause of death? this certificate hes 1 Yes 2 19 No 1 Yes 2₽No Be 25. Was case referred to medical 26. Place of Death (Check only ona) 9 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatlant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yas 2 No Investigation 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Certifier Medicai

The law requires that the death certificate be executed Box 68760. P.0. Records, Division of Vital or Attending Physician: offer death. Director: After this certifica To the Hospital or Atter within 24 hours effer des To the Funeral Director completely filled in by th

the Maryland

death with

filed within 72 hours efter

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Pages 1 and 2 should

21215-0020

Baltimore, Maryland

State Registrar

(Check only one)

29b. Signature and title of certified

31. Date filed (Month, Dey, Year)

9 1999

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)
Dr. Norberto Machiran
2938 Rosemar Drive Ellicott City, MI

32. Registrar's Signature

ATTENdING Physician

Ellicott City, MD 21043

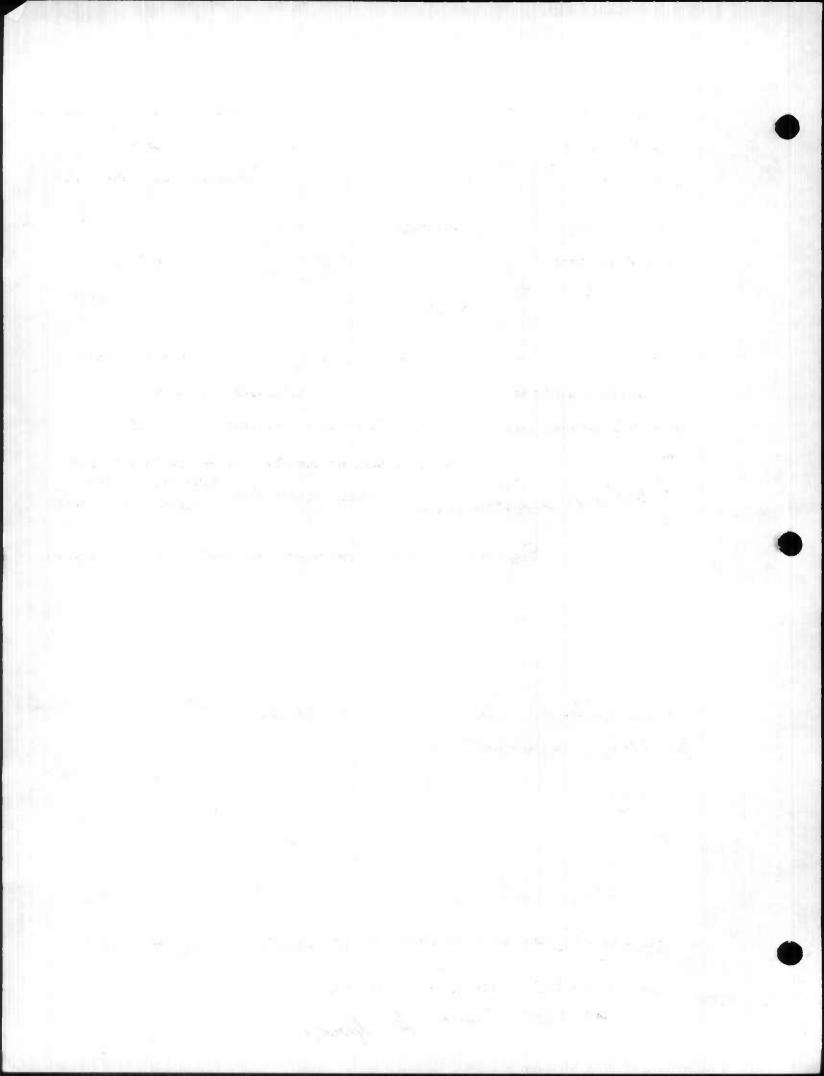
I'mera G. Sparks

29c. License number

29d. Date signed (Month, Dey, Yeer)

1999

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month KENNETH RUSSELL LOUDEN, Jr. /Medicai 4b. City, Town, or Location of Deeth 1999 16 10 4a. Fecility Neme (If not institution, give street end number) 4c. County of Death **Examiner** North Arundel Hospital Glen Burnie | If Under 24 Hrs. 8.1 | Hours | Min. Anne Arundel Co.

9. Birthpleca (State or Foreign Country) If Undar 1 Yaar 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** 1**2**0 M 2□ F Days Yrs. Director 49 213-52-3927 May 2, 1950 Balto., Md. to be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes No Anne Arundel Co. Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a death 15 Wendover Road Funeral U.S.A.
14. Race - American Indian, 21060 12. Was Decadent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 25 Married 1 Yes 2₺ No Specify: þ 3 Widowed 4 Divorcad Specify: White Hygiana. other than "natura ent, the Medical Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) .. Pages 1 and 2 should be filed w tment of Health and Mantel Hygia tant: If Itam 27 is marked other ti jury or other traumatic event, In other t TRUCK DRIVER Glen Burnie Hauling 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Meid Be Kennth R. Louden, Leona 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 20b. Placa of Disposition (Nema of cemetery, cremetory or other placa)

15 Wendover Road Glen Burnie, MD 21060
20c. Location - City or Town, Stata Sherry E. Louden (wife) 20a. Method of Disposition *Burial 2 Cremation 3 Removal from State Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery 7-8-99 Brooklyn Park, Md. 21. Signature of Funeral Service Licansi 22. Name and Address of Facility 4107 Wilkens Avenue HUBBARD FUNERAL HOME Baltimore, MD 21229 Do not enter the mode of dying, such as cardiac or respiratory arrest Im I e diseese, of complications that caused the heart failure. List only one cause on each line. **Physician** /Medical CArdiAc Insufficiency Immediate Cause (Final diseasa or condition resulting in death) Examiner Examiner The law requires that the deeth certificete be axecuted Sequentially list conditions, if any, leading to immediate cause. Enfer Underlying Cause (Disease or Injury that Initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Physician/Medicai Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? (AYCINOMA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy performed? cartificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Was case referred to medical exeminer?

1 Yes 2 No Be 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To in by the funeral 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftar t 1 Naturel 5 Pending Investigation To the Hospital or Attandli within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide to Cartifying Physician: To the best of my knowledge, deeth occurred at tha time, dete and place, and due to the cause(s) and manner as steled.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated. 29a, Certifier Medical completely 29b. Signature and titla of certifiar 29c. Licensa number 29d. Data signad (Month, Day, Year) Deputy

State Registrar

21215-0020

Baltimore, Maryland

P.O. Box 68760.

Records,

of Vital

Division

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31. Dete filed (Month, Dey, Year) 1/1/1000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JONES, MO 32. Registrar's Signeture

"enera G.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** 1810 Juli Moore /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, giva street end number) 4c. County of Deeth Examiner Medical VA Ballinore Ballimore Center Baltimore if Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Days Hours Min. (Month, Dey, Year) 9. Birthpiece (State or Foreign Country) VIRGINIA 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (in yrs. lest birthday) **Euneral** 231-36-453 Director MAY 01,192: Usuei Residence of Decedent with the Maryland 10e. Steta 10c. City, Town or Location 10d, Inside City Limits 10b. County r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 12 Yas 2 □ No MARYLAND Directo 10e. Street and Number 10g. Citizen of Whet Country? STREET Funerai U death Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Biack, White, etc. 12. Was Decedant Ever in U.S. Armed Forces? 11. Maritai Status filed within 72 hours after 1 N Yes 2 No 8-18-41 If Yes, Give 28-18-41 Year or Datas: 12-16-45 Never Married 2 ☐ Married 1 □ Yes 200No Baltimore, Maryland 21215-0020 λq BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) MAINTENANCE permit. Peges 1 and 2 should be filed to Department of Health and Mentel Hygis Important: If item 27 is marked other? 17. Fathar's Neme (First, Middla, Last) IRA 19b. Malling Address (Street end Number or Rulal Route Number, City or Town, State, Zip Code, 19e. Informent's Neme/Reletionship (Type, Print) BENTALOU ST. BALTIMORE MD. 2126 of Dete 20c. Location - City or Town, State ANNETTE MOORE(SISTER-IN-LAW) 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cramation 3 ☐ Removal from State eny Injury o JARRISON FOREST 07-09-99 OWINGS MILLS. 4 ☐ Donetion _5 ☐ Other (Specify) 22. Name end Address of Facility BROWN JR. FUNERAL HOME 2140 N. FULTON AVE, BALTO, MP. 21217 21. Signature of Funeral Service Lick 23a. Pert1. Enter the disease, or complications that clused the deeth. Do not enter the mode of dying, such as cardiac or raspiret shock, or heart feilure. List only one cause on each line. Approximete interval Between Onset end Deeth Physician /Medical Immediate Ceuse (Finel Pneumoma disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Physician/Medical Examiner duo denum adenocaranoma The law requires that the death certificate be executed attending physician and for use as the buriel-tran Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or es e consequenca of): Sepsis Box 68760. that initiated events resulting in death) Lest Due to (or es e consequenca of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. the 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown d peugi Kenal Failure Records, à 24b. Were autopsy findings evaileble prior to completion of cause of deeth? Completed 24e. Wes an autopsy Deen hes page 1 Yes RE No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) J. 1 Yes PINO 1 Inpatient 2 ER/Outpetlent 3 DOA 27. Menner of Deeth 28c. Injury et Work? Certification: 28d. Describe how injury occurred Neturei 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 29a. Certifier edicai (Check only one) 2 Madical Examinar: On the besis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end pieca, and due to the cause(s) and manner steted. 29d. Data signed (Month, Day, Year) 29b. Signeture end life of cartifiar 29c. License number MD P10006 July 30. Name and address of person who ted cause of death (item 23e) (Type, Print) Baltimore Greene Royal South

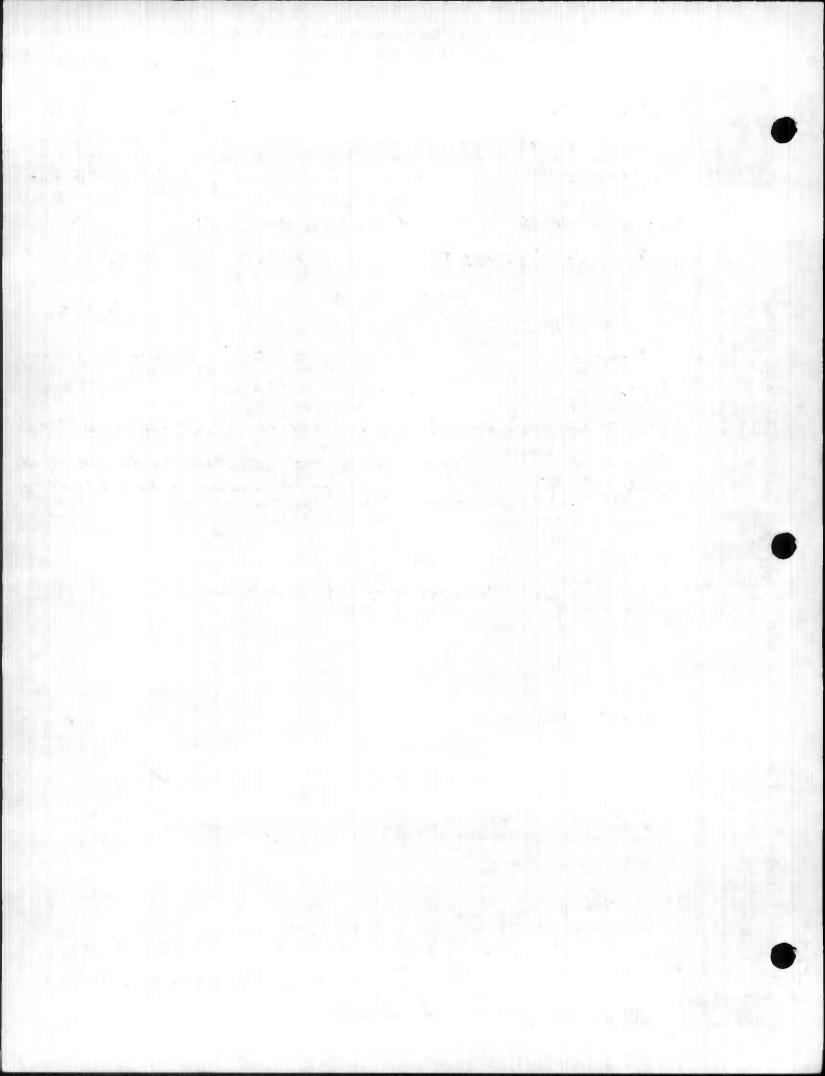
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31. Dete filed (Month, Dey, Year)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Day Month 9:55 AM 06 UL 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death KNOLLS (E BALT. If Under 24 Hrs. RVING ARE NIER THORE 8. Data of Birth (Month, Day, Year) SEPT. 03, 1909 7. Age (In yrs. last birthday) 9 Yrs. 5. Social Security Number Birthplace (Stata or Foreign Country) Days 228-14-424 1 M 2 F MAR Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1. Yas 2 □ No MARYLAND 10e. Street and Number 16g. Citizen of What Country? AVENUE MONDAWMIN USA 14. Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yas, Giva 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Nidowed 4 Divorced Year or Datas: 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BALTO. CITY PUBLIC OCHOOL TEACHER MASTER'S DEGREE 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Father's Nama (First, Middla, Last) EW15 MOORE ETHEL U. BOWLER 19a. Informant's Name/Ralationship (Type, Print) 9a. Informant's Namer renewal STEPDAUGHTS 4014 LAKE ESTHER LANDSDOLONE STEPDAUGHTS 4014 LAKE 20b. Place of Disposition (Nama of cematary, crematory or other place) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) BALTIMORE, HD. 212 16 20c. Location - City or Fown, Stata ARLISLE AVENUE 20s. Mathod of Disposition 1 Burial 2 Cremation 3 Removal from Stata Data 4 ☐ Donation 5 ☐ Othar (Specify) CEMETERY 107-12-21. Signature of Funaral Sen 22. Nama and Address of Facility JR. JOSE 2140 FULTON AVE MD.2121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a shipick, or haart failura. List only one cause on each lina. Approximats Interval Batween Onsat and Daath Immediata Causa (Final 1 month Massre Stocke disaasa or condition rasulting in death) Due to (or as a consequence of): 104-5 diseme ruscular Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Cause (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) Hypontonsian 2048 Due to (or as a consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 20 No 3 Probably 4 Unknown 24b. Wars sutopsy findings avsilable prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 ☐ Inpatienf 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

The law requires that the death certificate be executed and Box 68760. signed by the a P.0. Records. certificate Division of Vital or Attending Physician: After this within 24 hours after death. To the Funeral Director: A

Physician

/Medical

Examiner

Funeral

Director

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Funeral Director

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Physician/Medical Examiner

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Medical Certification: To

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Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 fa marked other than ary or other traumatic event, the Ma

permit. Page Department of Important: If any Injury or once.

Physician /Medical

Examiner

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Baltimore, Maryland

25. Was casa rafarred to medical axaminar? 1 Yes 2 No 27. Manner of Death 5 Pending invastigation 1 Tyes 2 No 2 Accident 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the tima, data and place, and dua to the causa(s) and manner stated. 29a. Certifier (Check only one)

29b. Signatura and titla of certifier

29c. License number

29d. Data signed (Month, Day, Year)

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30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) 4660 villas Arc Balhman OK DESHIM

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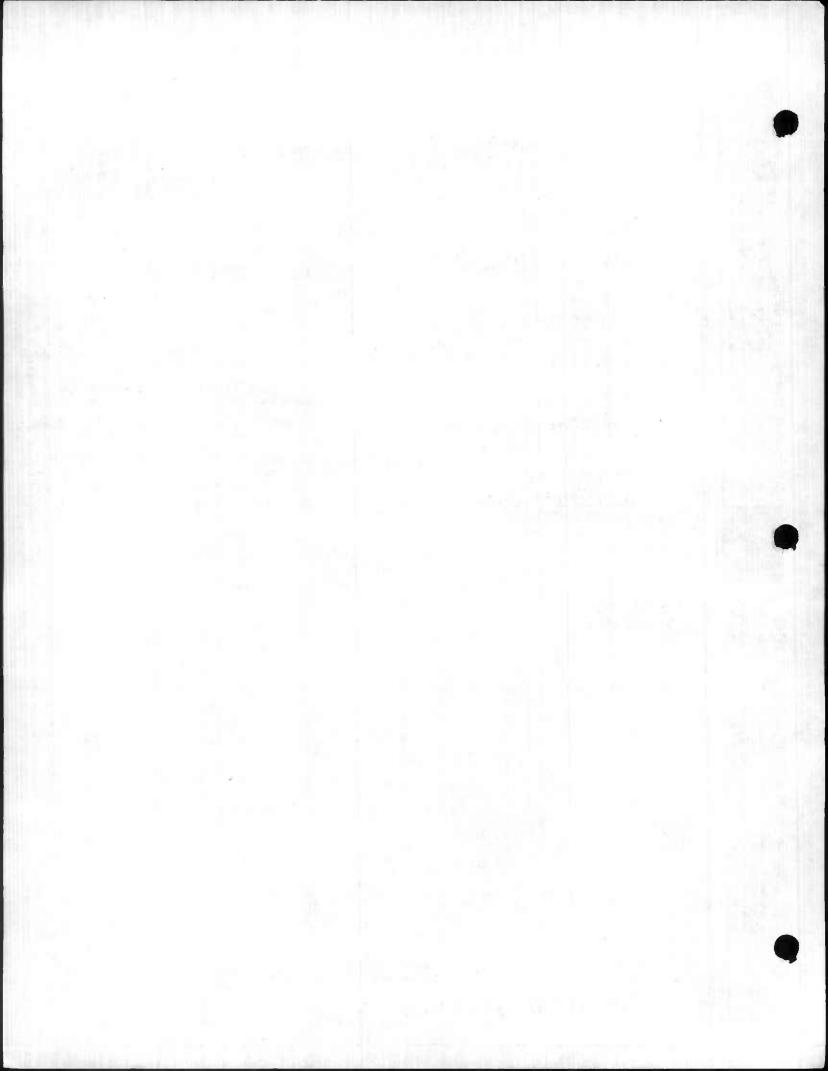
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State Registrar

DHMH 16 Rev 6/95

31. Data filed (Month PLY, Year) 9 1999





Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 7, 1999 July 5:05 Allen Mitzel Levere 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Carroll Co. Westminister Carroll County General Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) 5. Social Security Number Days Months Hours 15 M 2□ F Maryland 86 717-10-8906 Dec Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Carroll Co Westminister Maryland 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21157 156 East Main Street U.S.A 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Merried 2 Married 1 ☐ Yes ŽÍXNo Specity: Specify: White 3€Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Penna Elementery/Secondery (0-12) College (1-4or 5+) Conductor 6 Railroad 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Julian Allen Charles Warren Mitzel 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1105 West 42nd Street, Baltimore, Maryland 21211 Charles Mitzel (Son) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removel from Stete 7/9/99 Jessop UMC Cemetry Cockeysville, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name end Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 23a Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21211 Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypoxemia Due to (or as a consequence of): 3 days Pneumoniti Due to (or es a consequence of) Due to (or as a consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2K No 1 Tyes 2 No

Physician /Medical Examiner

that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

permit. Pages 1 and 2 should be Department of Health and Mental Important: If Nem 27 is marked of

Physician

/Medical

Examiner

10a. Stete

Directo

Funeral

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Completed

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Funeral

Director

"natural", or thems 23s or 25s-f show

altimore, Maryland 21215-0020

Examine Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Diseese or injury that initialed events resulting in death) Last Physician/Medical by Completed

25. Was case referred to medical	26. Place of Death (Check only one)				
examiner? 1 ☐ Yes 2 ☑ No	Hospitel: 1 Inpatient 2 ☐ ER	R/Outpatient 3 DO	Other: 4 Nursing F	Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. Manner of Death 1 ☑Netural 5 ☐ Pending 2 ☐ Accident investigation	28a. Dete of Injury (Month, Day Year) 28	8b. Time of Injury M	c. injury at Work? 1 Yes 2 No	28d. Describe how injury occurred	
3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of injury - At home building, etc. (Specify)	e, ferm, street, factory,	office	28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29e. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signature and title of cartifier

29c. License number

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) LISA Kim, m.D. at Carroll County

m.D.

D 52479

Hospital Genera 31. Dete filed (Month, Day, Year)

0 9 1999

at 200 memorial ⊿32. Registrer's Signeture

Avenue, Westminster, MO 21159

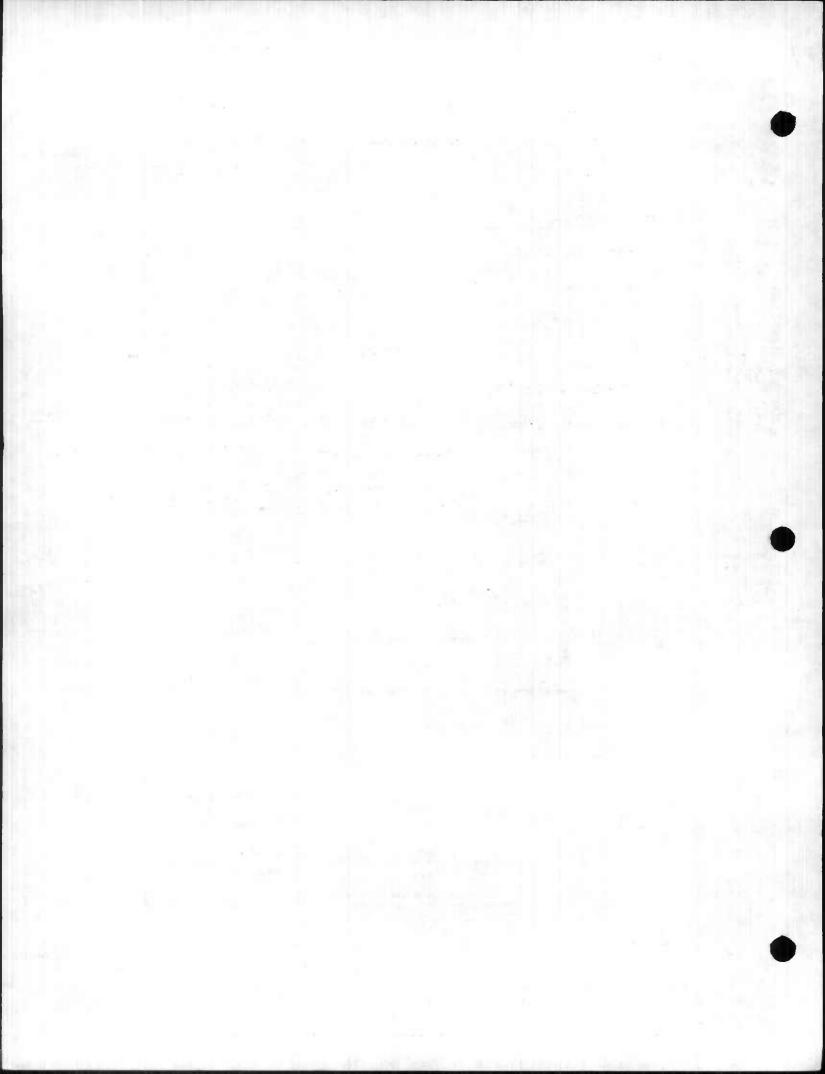
State Registrar

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

Be

edical Certification: To



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey **Physician** McKenzie Parrie 1999 12:20 DM July /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner CITY BALTIMORE THE JOHNS HOPKINS HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) AUG 9, 1964 Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Deys ₩ 2 D F Months Hours 217-94-7586 34 Yrs. Georgia **Director** Usuel Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show yinjury or other traumatic evant, he Medical Examine must be notified exam. 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location MD N/A Baltimore Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21211 USA 3524 Greenspring Avenue Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. Never Married 2 Married Specify: Black 1 Yes 2 No Specify: by 3 □ Widowed 4 □ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Food Service Cook 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Oscar James McKenzie Rosa Mae Harris 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 3524 Greenspring Ave. Baltimore, MD 21211
a of Disposition (Name of Dete 20c. Location - City or Town, Stete Oscar J. McKenzie/father 20b. Pieca of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 1 ☐ Buriel 2 X Cremetion 3 ☐ Removal from State Metro Crematory, Inc. 07/08/99 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) Cremation Society of Maryland, 21. Signeture of Lundral Service Licensee C 299 Frederick Rd. Baltimore, 21228 Dawn F. McDonald | 299 Frederick Kd. Dalling

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final Acidosis disease or condition resulting In deeth) Examiner Due to (or es e consequence of) Examiner Huper kalema physician end the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury thet Initiated events resulting in deeth) Lest Due to (or es e consequence of): Stage Renal Disease Physician/Medical Due to (or as e consequence of) signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Hypertension þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy Completed Pericardial Effusion certificeta has lirector, page 2 s 1 ☐ Yes 2 No 1 Yes 2 No or Attending Physician: director, Be 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nnpatient 2 ER/Outpetient 3 DOA Certification: To this funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dev Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 5 Pending 1 Neturel s after des. 1 Yes 2 No Investigation 2 Accident in 24 hours. The Funerei Directory filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} Hospital 1X Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a, Certifier Medicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture and title of cartifier 29c. License number Resident RES-000 July 5, 1999

Registrar **DHMH 16 Rsv 6/95**

Division of Vital Records, P.O. Box 68760.

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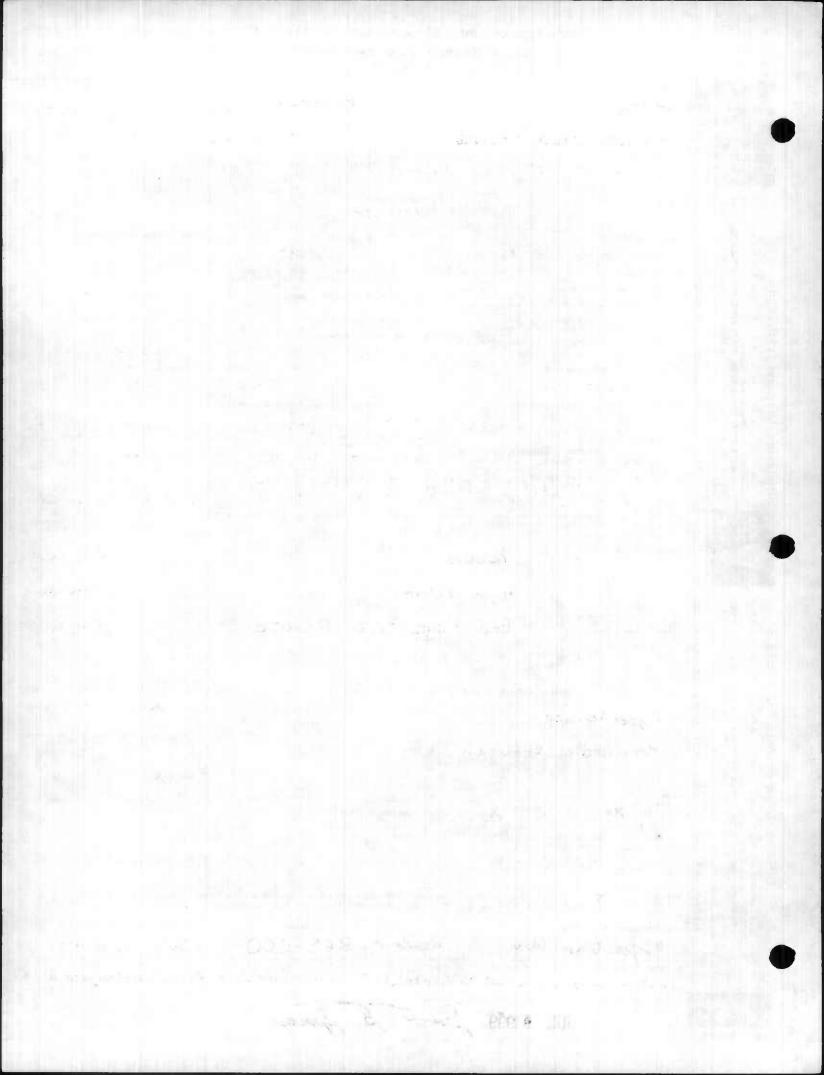
31. Dete filed (Month, Dey, Year)

Justina Wu

32. Registrer's Signeture

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)

Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death ahoney 01 4b. City, Town, or Location of Deeth ecility Name (If not institution, give street and number 4c. County of Death Ellicatt Cit Tapes Nivising + Rehab Contr 8. Dete of Birth (Month, Dev. If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 6. Sow 1 M M 2 □ F Birthplace (State or Foreign Country) 292/b429DA Usuel Rasidence of Decedent Deys Months Hours Min. 89 Yrs 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 2 Yes 2 □ No Baltimore Catonsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 117 Wyndcrest Avenue 21228 USA 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Rece - American Indien. Black, Whita, atc. 1 ☐ Yes 2 No It Yes, Give Yaer or Detas: 1 Never Married 2 X Merried 1 ☐ Yas 2 No Specify: Specify White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) 12 Structural Engineer Engineering 17. Fether's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumeme) Mary Shea John J. Mahoney 19e. Intormant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 117 Wyndcrest Avenue, Catonsville, Md21228 Dorothea Mahoney/wife 20e. Mathod of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, Stata 1 variei 2 ☐ Cremation 3 ☐ Ramoval from Steta 8/12/99 Baltimore, Md 4 □ Donetion 5 □ Other (Specify) Woodlawn Cemetery 22. Nama and Addrass of Facility 21. Signatura of Funaral Sarvice Licensae Sterling Ashton Schwab Funeral Home, Inc Yeurs 21228 736 Edmondson Avenue, Balto, Md. Approximete Interval Batween Onset end Deeth 23a. Pert1. Enter the diseese, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line. Immediata Causa (Final diseasa or condition resulting in deeth) CVA (Cerebasuanular acident, mon My Renal Frilux month Sequentielly list conditions, if eny, laeding to immediata cause. Enter Underlying Ceuse (Diseese or Injury that initieted events rasulting in death) Last Due to (or es e consequence ot): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the undarfying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown anenia Ch romai Essent al Hypertenin 24b. Were eutopsy findings eveilable prior to completion of cause of daeth? 24e. Wes en eutopsy performed? 2 UNO 1 Yes 1 Yes 20 No

Physician /Medical Examiner

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Funeral

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permit. Pages 1 and 2 should be filed within 72 hours efter Department of Health and Mental Hygiens. Important: If flem 27 is marked other than "natural; or file any in-jury or other traumatic event, me Moster Examine.

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Division of Vital Records, or Attending Physician: after deeth, Director: After this carifica funerai 6 re Funeral Direction of Particular Plants of Partic

completely within 2 To the State 25. Wes casa ratarred to medical exeminer? 26. Place of Deeth (Check only ona) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Dascribe how Injury occurred 27. Menner of Death 28b. Time of 28c. tnjury at Work? 28a. Data of Injury (Month, Dey Year) 5 Panding Invastigetion 1 DNaturel 1 Yas 2 No 2 Accident 6 Could not be detarmined 28e. Pleca of Injury - At homa, ferm, streat, fectory, offica building, etc. (Specify) 3 Suicide 28t. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicide 29a. Cartifiar 1 Decrifying Phyatctan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signetura and titla of certifiar 29c. Licansa number

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July 6, 1999

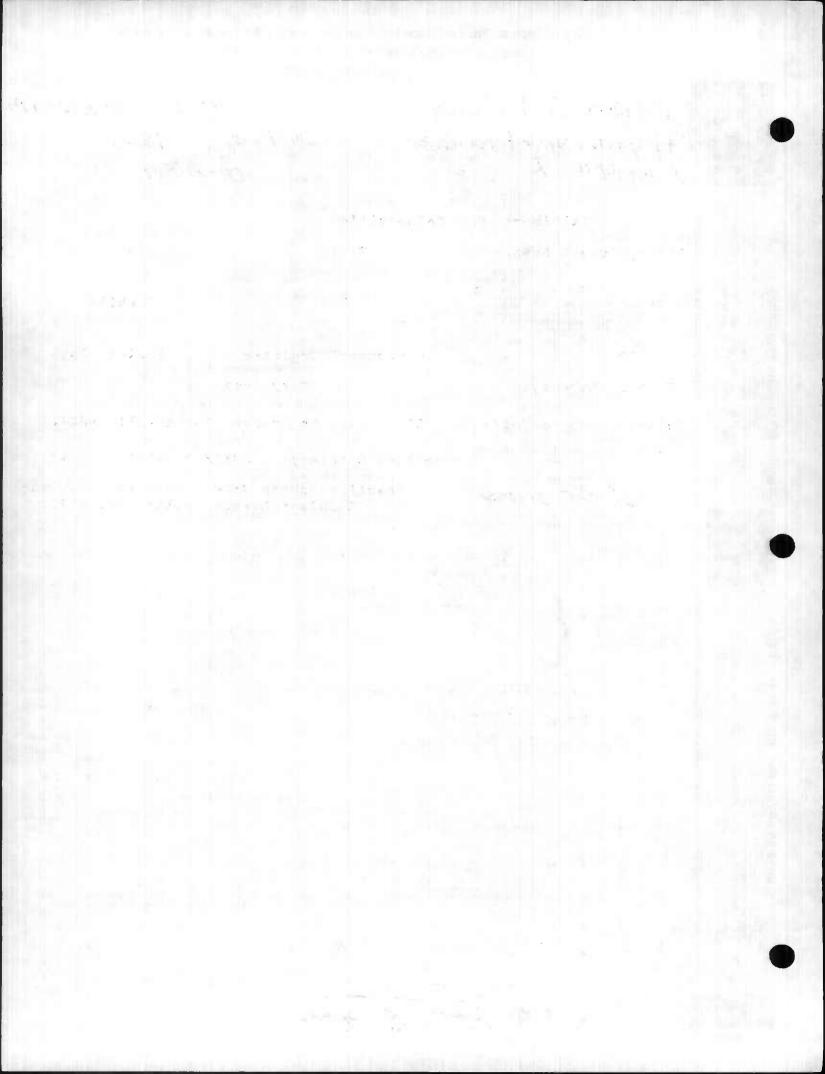
30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

Frederice Road Suite 162 ROLENA SABUNDAYO, mo

31. Dete tiled (Month, Dey, Year)

32. Registrar's Signature JUL

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Tima.of Death 1. Decedent's Name (First, Middla, Last) July 7, Day 1999 Richard Brooks Magers 3:30 a.m. 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Westminster Carroll Carroll Lutheran Village If Under 1 Year 8. Date of Birth Peo. 25, 1917 9. Birthplace (State Maryland 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 15 M 2□ F 82 213-12-4218 Yrs. Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Baltimore Towson 1 Yas 2 No Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 U.S.A. 1534 Doxbury Rd. 12. Was Decedent Ever in U,S. Anned Forces? 1 A Yes 2 □ No If Yas, Give Year or Dates: WW II 14. Raca - American Indian. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Dairy Salesman 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) Albert Hobson Madalyn Pfieffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1534 Doxbury Rd., Towson, Md. 21286 Barbara Jeunette - Daughter 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 9, 1999 Baltimore, Md. Metro Crematory 21. Signature of Fitneral Service License 22. Name and Address of Facility 21117 Eckhardt Funeral Chapel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, Approximate Approximata Interval Between Onset and Death Congestine Heart Failure Syrs Immediate Cause (Final disease or condition resulting in death) 11 Atherosclerusi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown acciden 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy

Physician /Medical **Examiner**

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To the Hospital or Attai within 24 hours after dei To the Funeral Director completely filled in by th

requires that the death certificate be executed

Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Physician

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permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Meryle Department of Heelth end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s4 show any injury or other traumatic event, the Medical Example mental and all and all and any injury or other traumatic event, the Medical Example.

Baltimore, Maryland 21215-0020

Examiner Physician/Medical 80 certificate has t lirector, page 2 s

Completed 25. Was case referred to medical 10

26 Place of Death /Check only one)

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examiner? 1 ☐ Yas 2D No	fospital: 1 Inpatient 2	ER/Outpatient 3 DOA	Other: 4 Nursing Home	5 ☐ Residenca 6 ☐ Other (Specify)
	28a. Date of Injury (Month, Day Year)	28b. Time of 28c.		Describe how injury occurred

6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Dafe signed (Month, Day, Year) 29c. License number

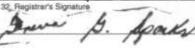
29b. Signatura and fittle of cartifier

51705

30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)
M. PANSURIYA, MD 419F Malcolm DR, Wastonimter mod 21157

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth Dey 1999 Yeer July Eleanor Moritz 4, 12:15am 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death 719 Maiden Choice Lane Brookside #202 Baltimore Baltimore 5 Sociel Security Number If Under 1 Year if Undar 24 Hrs 9. Birthplaca (Stete or Foreign Country) Maryland 7. Age (In yrs. lest birthdey) 1□ M 2∑ F 214-38-6283 86 Vire Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 719 Maiden Choice Lane Brookside202 21228 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indien, Bleck, Whila, elc. 1 Naver Married 2 Married 1 ☐ Yas 2 X No If Yes, Give Yeer or Dates: 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Teacher Junior High School 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Surname) Philip Dougherty Nellie McCarthy 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Francis X. Moritz/Husband 719 Maiden Choice Lane BR202 Baltimore, Maryland21228 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBuriel 2 Cremetion 3 Removal from State Lorraine Park Cemetery 7/8/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Hubbard Funeral Home, Inc. Homas uanita () 4107 Wilkens Avenue Baltimore, Maryland 21229 23a. Part 1 Parter tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, should be heart fallure. List only one ceuse on each line. Approximete tnterval Between Onset and Deeth Immediate Ceuse (Finel 6 mus diseese or condition resulting In deeth) cancer Due to (or es consequence of) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initieted events resulting in deeth) Last Due to (or es e consequence of) Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yes 2 No 1 Yas 2 No 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Waturel 5 Pending 1 ∏Yes 2 ∏No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 28e. Place of Injury - At home, farm, streat, factory, office building, efc. (Specify) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) and manner as stated. 29a. Certifier

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Physician/Medical Examiner

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Certification: To

(Check only one)

29b. Signature and title of certifier

31. Dete filed (Month, Day, Year)

Funeral

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Completed

the Maryland

Baltimore, Maryland 21215-0020

State Registrar

JUL 9 1999

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32. Registrar's Signeture

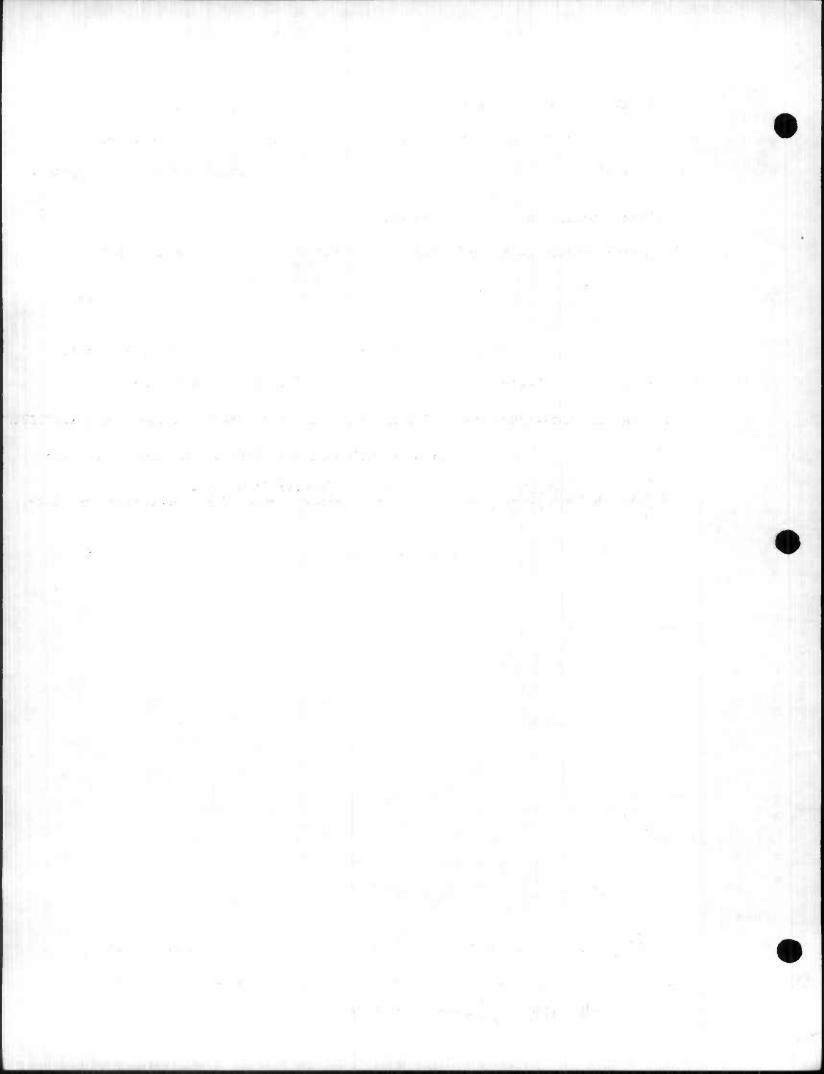
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2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner stated. 29d. Dete signed (Month, Dey, Year)

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30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

Baltonia Md 21229



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

ee AMENDS:	#23 PART I, 27, 28A-F P	State of Ma	aryland / E	epartmer	nt of l	Health and I	Mental Hyg	jiene 9) 2	1701		
Muritos.	Decedent's Nama (First, Middle, Las			Certificat	ie oi	Dealli	2. Data of Dea	leg. No.		3. Time of Death		
Physician							Month Month	Day	Year	S. Tima or Death		
/Medical Examiner	Linda L 4a Facility Nama (If not institution, give	ee Norton				4b. City, Town, or I	July Location of Death	05 4c. County	1999 of Death	00:05 AM.		
	20536 Shadyside Way Germant							town Montgomery				
Funeral	5. Social Security Number 6. Se	7. Ag	e (In yrs. last birt	hday) If Unde Months	r 1 Yaar Days	If Under 24 Hrs.	8. Date of Birth (Month, Day	irth 9. Birthplace (State		place (State or Foreign		
Director	213-46-9676 Usuat Residence of Decedent	□ M 2□ X F	53	Yrs.	Duys	7,0010	NOT 0 10/5			f-Columbia		
of show	10a. Stata 10b. County		10c. City, Town						1	10d. Inside City Limits		
be notified Director	Maryland Montgo	mery		(ern	nantown				1 Yes 2 No		
23a or 2 al Dire	10e. Street and Number			10f. Zij	p Code		1	log. Citizen of \	What Cour	ntry?		
	20536 Shadyside					374-2832		_	SA			
Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		13. Was Dece If Yes, spe	dent of locify Cub	Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No- o Rican, atc.)		e - Amaric ck, Whita,	ean Indian, etc.		
by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🐼 Ñ If Yes, Give Year or Dates:	₩o	1 ☐ Yes	Specify:		Specify	w Wh	ite			
ed within 72 hours efter yglene. Nor then "naturelt, or he it, the Hedical Extranor Completed by Fu	15. Decedent's Edu (Specify only highest grad	ucation le completed)	16a.	Decedent's Usu (Give kind of wo	Decedent's Usuel Occupation Giva kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry			
hojdu	Elementary/Secondary (0-12)	College (1-4or 5	i+)			ed)						
BEE O	47 Fabrus M	4	I I	Iomemak	cer	1 40 40 11 11		Dome				
8	17. Father's Nama (First, Middle, Last)						ame (First, Middle, Maiden Surnama) Anna Malcom					
2	James Stra											
ss 1 and 2 should by of Health and Mente Hem 27 le marked other treumatic ev	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code Richard Martin Norton husband 20536 Shadyside Way Germantown, MD 208 20a. Method of Disposition 20b. Place of Disposition (Name of Data 20c. Location - City or Town, S											
	20a. Method of Disposition	20c. Location -	Location - City or Town, State									
	1 Burial 2 Tremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, crematory or other place) 7/7/99 Baltimore, MD											
	21. Signature of Funeral Service Lipens Dawn F. Mc	Donald	mald	Crema 299 H	nd Addr itio	ess of Facility On Socie derick R	ty of l	Maryla	nd, re.	Inc. MD 21228		
an cal	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediala Cause (Final disease or condition resulting in death)	ne cause <i>on</i> aach lir	ne.			IBROSIS OF			TOSIS	Approximete Interval Between Onset and Death		
ě			Due to (or as a c	consequence of)	:				1			
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	в.	Due to (or as a c	onsequence of)								
Medical												
Physician/Med	Part II. Other significant conditions co	ntribution to death by	ut not resulting in	the underlying	Pausa Ai	iven in Part I	23h Dld 1	nhacco usa co	ntribute 1	o the cause of death?		
		in build to double of	1 U Y	2.5		bebly 4 Unknow						
Completed by										ara autopsy lindings vallable prior to empletion of causa death?		
Somp							12 Y	es 2 No	1/2	Yas 2 No		
director, page 2	25. Was case referred to medical examiner?						ath (Check only or	na)				
	tv Yes 2□ No		nt 2 ER/Out		UA		loma XX Resid			(y)		
on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injui (Month, Day	/ Year) In		28c. Inju		28d. Describe h	ow injury occur	red			
Certification:	2 ☐ Accident investigation	FOUND: 7-4-	.99 FOU	ND: M	1	Yes 2 No	UNKNOWN					
E	4 Homicide							treet and Numb n, Stata)	per or Run	al Routa Number,		
3		FC	OUND AT HO	ME			20536 SHA	DYSIDE GE	RMANT	OWN, MARYLANI		
edicai		sician: To the best of ner: On the basis of	axamination and									
Med		and manner sta	ned.	20	e Linea	se number		29d. Data signe	d (Month	Day Yearl		
-	29b. Signature and title of certifier	1 11	1	29	C. LICEN	SO HUHIUUF		.ou. Dela signe	ru (muriti),	way, rear		
	MUSVI	1 -00	uco	ZMD	0	.C.M.E.		July	7 5,	1999		
	30. Nama and address of person who co	ompleted cause of de	eath (Item 289) (Type, Print)								

State Registrar

DHMH 16 Rev 6/95

Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201
31. Data filed (Month, Day, Year)

32. Registrents Signature

JUL 91999>

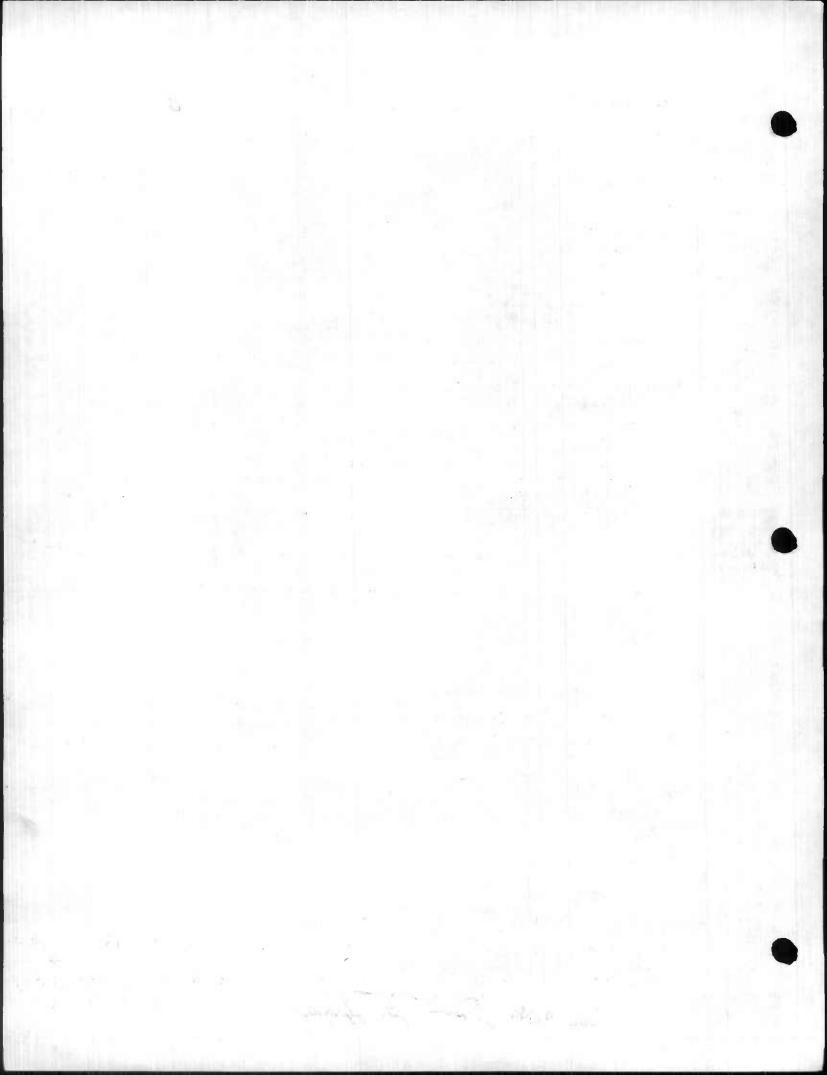
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** THEODORE 13. NIEBERDING 3:05 pm JULY 199 /Medical 4a Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL CHUREH BALTIMONE HOME If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 6 Sax 7. Age (in yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dev. Year) **Funeral** 10M 2DF Months Days Hours Min Director 75 217.20.2160 Usual Residence of Decedent Maryland July 7,1923 the Manyland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examinar must be notified at 1 Nes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 602 North Decker Avenue 21205 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 14. Race - American Indian, Black, Whita, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Merried 2 ☐ Merried Maryjand 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry e filed within 7 al Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Worker Ackerman & Baynes traumatic event, 17. Father's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) 12 should be fil h and Mental H Is marked oth Theodore Bernard Nieberding, Sr. Louise Monk 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 end 2 st Department of Heelth and Important: If Nem 27 ia n any Injury or other traun Dorothy Nieberding Same as above Baitimore, 20b. Plece of Disposition (Nama of cemetary, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 Donation 5 DOther (Specify) Baltimore-Washington 17/8 Laurel, Md. 22. Name and Address of Facility Moran-Ashton Funeral Home 21. Signature of Fungral Service Licensee 3000 E. Baltimore St., Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or hear failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finat 72 hours Da disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner 2 week sttending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of) Box 68760, Physician/Medical that initieted events resulting In death) Last Due to (or es a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, P 24b. Were sutopsy findings svailable prior to completion of cause of death? 24a. Was an autopsy performed? Myoral 1 Yes 25 No 1 Yes 2 70 Division of Vitai 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Attending 5 Pending investigation 1 Yes 2 No death. 2 Accident or Attend after death Director: / 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29e. Certifier edical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier DO053471 Valy 6, 1958 runs 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) N. Brokoway, BACT. MD 2123/ PAMITTON, 32. Regisyar's Signature 31. Date filed (Month, Day, Year)

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State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #25 PER MD G773 7-8-99 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUNE 30, 1999 **VERA** NORRIS E. 6:AM 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 2413 Annapolis Road Baltimore City If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (Stete or Foreign Country) Days 1 ☐ M 2 💢 F 89 Yrs. Jan. 4, 1910 Maryland 217-26-8093 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits XX Yes 2 No City Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2413 Annapolis Road 21230 U.S.A. 13. Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S Armed Forces? 14. Raca - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: White 1 Yes 2 No Specify: 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Busineas/Industry Elementery/Secondary (0-12) College (1-4or 5+) 9th Clothing Manufacturer Seamstress (Ret.) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Edgar South Bertha Lettau 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 322 S. Payson Street Baltimore, Maryland 21223 Wilton H. Norris, Jr. (son) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
4 Donetion 5 Other (Specify) Loudon Park Cemetery 7/3/99 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name end Address of Facility 4107 Wilkens Avenue HUBBARD FUNERAL HOME lanner Baltimore, MD 21229 that claused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Enter the disease, or complications that caused the control of the Approximate terval Between Onset end Death Immediate Cause (Final disease or condition resulting in deeth) Mouth Due to (or es e consequenca of) Due to (or es a consequence of) Due to (or as e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Was an eutopsy performed?

Physician /Medical Examiner

and

physician

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Completed

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Certification: To

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Box 68760,

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Physician

/Medical

Examiner

Funeral

Director

28a-f show munt be notified at

ò Items 23a

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nt of Health a : If Item 27 is

permit. Page Department of Important: If any Injury or once.

Funeral

by

Completed

the

72 hours after

Baltimore, Maryland 21215-0020

Examiner Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Physician/Medical

29b. Signeture end title of certifier

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 3 5 ☐ Pending 1 Yes 2 No Investigation 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end pleca, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier

Records, Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this cartificatal filled in by the funeral director, within 24 hours after To the Funeral Dire complately filled in b

State

Registrar

29c. License number

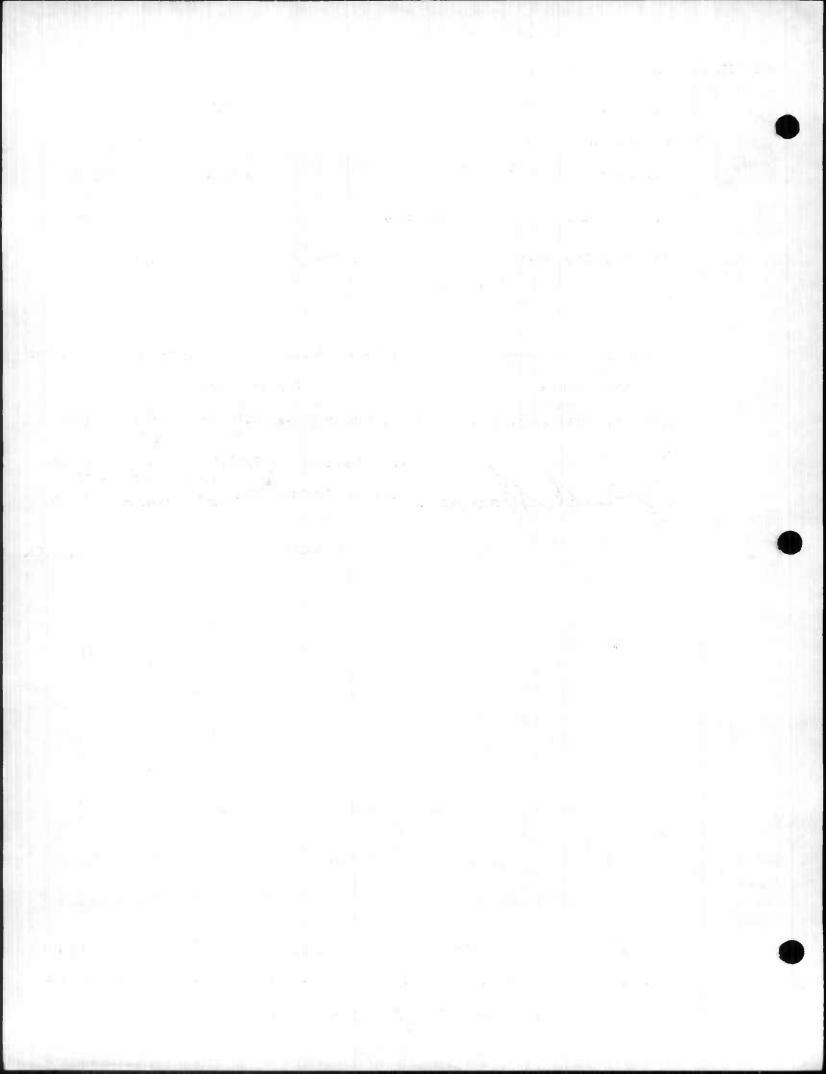
D39505

29d. Date signed (Month, Dey, Year)

June 30, 1999

1600 Crain Pury, Glen Burnie, MD. udhish markan 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture JUL

30. Name and address of person who completed cause of death (item 23a) (Type, Print)



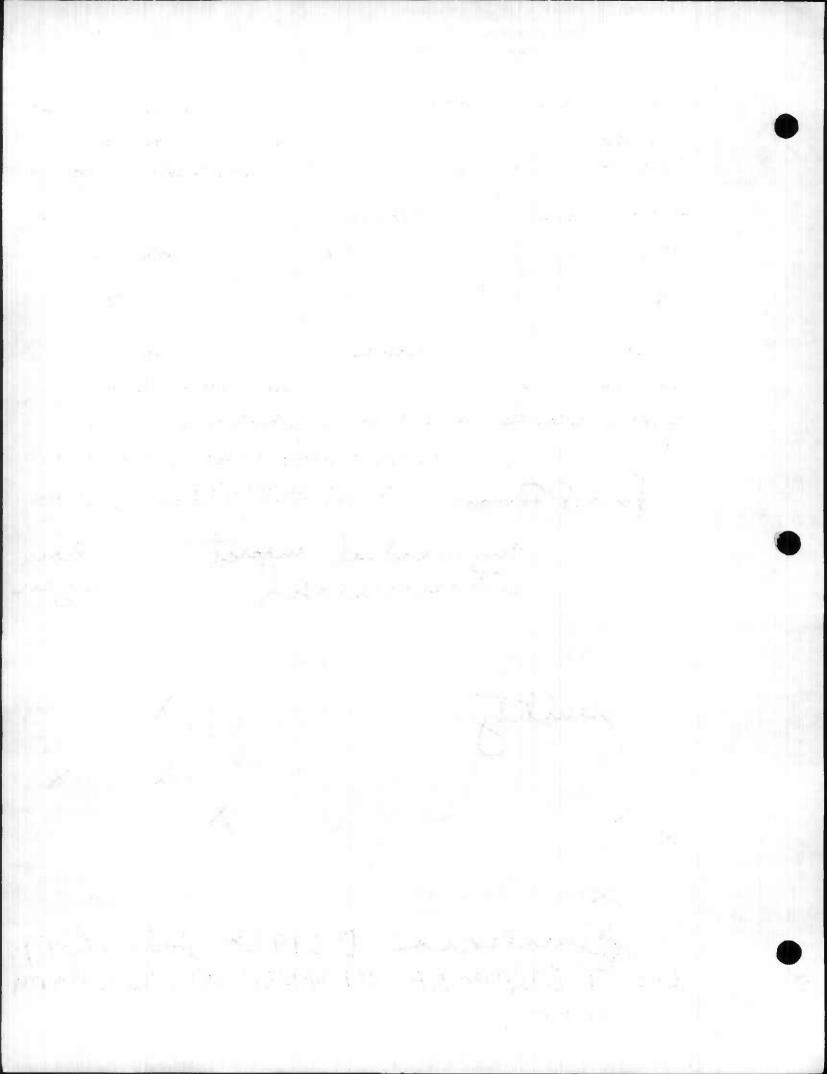
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Eileen Helen Nicodemus July 6, 1999 11:49am /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4331 Allen Drive Baltimore Baltimore 8. Date of Birth (Month, Day, Yaar) Nov. 5, 1918 5. Social Sacurity Number If Undar 1 Year If Under 24 Hrs. 9. Birthpleca (Stata or Foreign Country) Maryland 7. Aga (In yrs. last birthday) **Funeral** Days Hours Min 1 ☐ M 2 🂢 F 217-80-0283 80 Yrs. Director Usual Residence of Dacadent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f ahow notified at Maryland Baltimore Baltimore 1 ☐ Yas 2 XNo Director 10e. Streat and Number 10f. Zip Coda 10g. Citizen of What Country? 'netural', or items 23s or the Medical Examiner must be 4331 Allen Drive 21229 United States Funeral Was Decadant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status Was Dacedant Evar in U,S. Armad Forcas? 14. Race - American Indian Bleck, Whita, atc. 1 Navar Married 2 Marriad □Yas 2X No Yas, Giva Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: White þ Specify: 3 □Widowad 4 □ Divorcad Yaar or Datas: Completed 16e. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Card. Elamantary/Sacondary (0-12) Collaga (1-4or 5+) Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be permit. Pages 1 and 2 should be Department of Health and Mental important: If them 27 is marked or John Albert Muse Agnes Marie Morhiser 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Routa Number, City or Town, State, Zip Code) Eileen H. Nicodemus/Daughter 4331 Allen Drive Baltimore, Maryland 21229 20b. Plece of Disposition (Name of cemetary, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata H Buriel 2 ☐ Cramation 3 ☐ Ramovel from Stata ò New Cathedral Cemetery 7/10/99 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signatural Funeral Sarvica Licansaa 22. Nama and Addrass of Fecility Hubbard Funeral Home, Inc. Manita 4107 Wilkens Avenue Baltimore, Maryland 21229 tromas The rithe disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, earl failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician /Medical Immediete Ceuse (Finel diseasa or condition rasulting in daath) **Examiner** Examiner certificate be executed Sequantially list conditions, if eny, leading to immadiata causa. Entar Underlying Causa (Disaase or injury that initieted events resulting in daath) Last Due to (or es a consaguança of): P.O. Box 68760, Physician/Medicai Dua to (or as a consequence of) for use es The law requires that the death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? signed by t 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? peeu complation of causa of death? pege 2 : Division of Vital Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica Be 25. Was casa rafarred to medical 26. Place of Death (Check only one) axeminar? Hospital: Othar: 4 Nursing Home 1 Yas 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA edicai Certification: To 6 ☐ Other (Specify) funerai 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Discribe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Panding invastigation Natural 2 Accidant 1 Yas 2 🗌 No 6 Could not be determined 3 Suicida 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) à To the Hospitar or within 24 hours effer To the Funeral Director To the Funera 4 Homicida The critifying Physician: To the best of my knowledge, deeth occurred et the time, deta and place, and due to the ceuse(s) and manner as stated.

Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated. 29a. Cartifian 29b. Signatura and IIII Licansa number MAIDEN CHOIC 31. Data filad (Month, Dey, Year) State

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Registrar

9 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadant's Name (First, Middla, Last) 2. Date of Deeth Day Carol Ann Oliver July 07, 1999 6:00 am 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Gilchrist Center Towson Baltimore JAN 21, 1949 5. Sociel Security Number 7. Age (In yrs. lest birthday) 50 yrs. If Under 1 Year If Under 24 Hrs. Birthplece (Stete or Foreign Country) 1 □ M 2 □ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ Months Hours Yrs. Pennsylvania 160-40-6878 Usuel Residence of Decedent 10e. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits Yes 2□No N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1235 Limit Avenue 21239 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☒ Divorced White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 5 + Collaga (1-4or 5+) Master Patient Index Consultant Medical Records 17. Fathar's Name (First, Middla, Last) 18. Mother's Nema (First, Middle, Maiden Sumama) William 01iver L. Shirley Clark 19a. Informant's Neme/Ralationship (Typa, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Sarah Buxton/friend 1235 Limit Ave. Baltimore, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other piece) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory, Inc. 07/08/99 Baltimore, Cremation Society of Maryland, Inc. Edward A. 299 Frederick Rd. Baltimore, MD 21228 Dications thet ceused the death. Do not antar the mode of dying, such as cerdiec or raspiratory errest, one cause on each line. Interval Between Onset end Deeth BREAST Immediata Ceusa (Final diseese or condition resulting in death) Sequentially list conditions, if any, leading to Immediata ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest Dua to (or es e consequence of): Due to (or as e consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? FIBRICIATION 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings eveileble prior to completion of ceuse of deeth? 24a. Was an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Dether (Specify) NOSPICE 1 Yas 2 No 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Tima of 28d. Describe how Injury occurred 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be axed 68760 the Box (0 ۵ Records. gned Vital or Attending Physician: of this After Division s after death. filled in by the To the Hospital of within 24 hours at To the Funeral D completaly filled in

Physician/Medical by Be Completed 2 Certification:

Physician

/Medicai

Examiner

Funerai

Director

the notified at

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Department of Health I Important: If item 27 is any injury or other tra

Physician /Medical

Examiner

Berns (

Funeral Director

Be Completed by

Medical

4 Homicide

29a. Certifier

28e. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify)

29c. License number 030433

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and menner es steted.
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the causa(s) end menner stated. 29d. Date signed (Month, Dey, Yeer)

ST BATIMORE MO 21204

Name and address of person who completed caused. 31. Data filed (Month, Day, Yaar)

29b. Signeture end title of certifier

32. Registrar's Signature

of death (Item 23a) (Type, Print)

Registrar

State

DHMH 16 Bey 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10:40 4b. City, Town, or Location of Death ELIZA O'BERRY 1999 4c. County of Death 4e Fecility Neme (If not institution, give street and number) FORESTHAVEN NURSING HOME BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 ■ M 2 1 F Yrs. 214-26-3973 77 04-02-1922 BARNESVILLE, SC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7000 ROCKFIELD RD U.S.A. 14. Race - American Indian, 21244 12. Was Decedent Ever In U,S. Armed Forces? 1 Yes 2 No 11. Merifel Stefus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Merried 2 ☐ Married Specify: BLACK 1 Yes 2 No Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) SELF EMPLOYED 1.1 DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOHN GARVIN HATTIE CARTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) 7000 ROCKFIELD RD, BALTO. YVONNE OBERRY, DAUGHTER MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Deurial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) GARRISON FOREST 7-12-99 OWINGSMILLS, MD 21. Signature of Furieral Service Licensee 22. Name and Address of Fecility HOWELL FUNERAL HOME 23a. Part. Enter the disease, or complication; that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BALTO. MD = 21.207Approximate Interval Between Onset and Death SMALL RSTRUCTON Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown SECONDARY TO STROKE 24b. Wera autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 LNC 1 Yes 2 No 25. Was case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Records, P.O. Box 68760

27. Manper of Death

Naturet

2 Accident 3 Suicide

4 I Homicide

(Check only one)

31. Date filed (Month, Day, Year)

JUL

29a, Certifier

Examiner the burial-tran and Physician/Medical þ Completed pege 2 Be P funeral Certification:

Physician

Examiner

Funeral

Director

ns 23a or 28a-f ahow

item 27 ia merked other than "natural", or items other traumatic event, the Medical Examiner m

permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is merked other than "natural", or ther any Injury or other traumatic event.

Physician

/Medical

Examiner

altimore, Maryland 21215-0020

Director

Funeral

p

Completed

Be

with the Maryland

death

/Medical

signed by certificate

Division of Vital Hospital or Attending Physicien: 24 hours efter death. Funeral Director: After this certifica

> State Registrar

Medicai

29b. Signature and title of certifier Queen

9 1999

5 Pending Investigation

6 Could not be determined

29c. License number 28595

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASNEEM

CARHANI,

28e. Date of Injury (Month, Day Year)

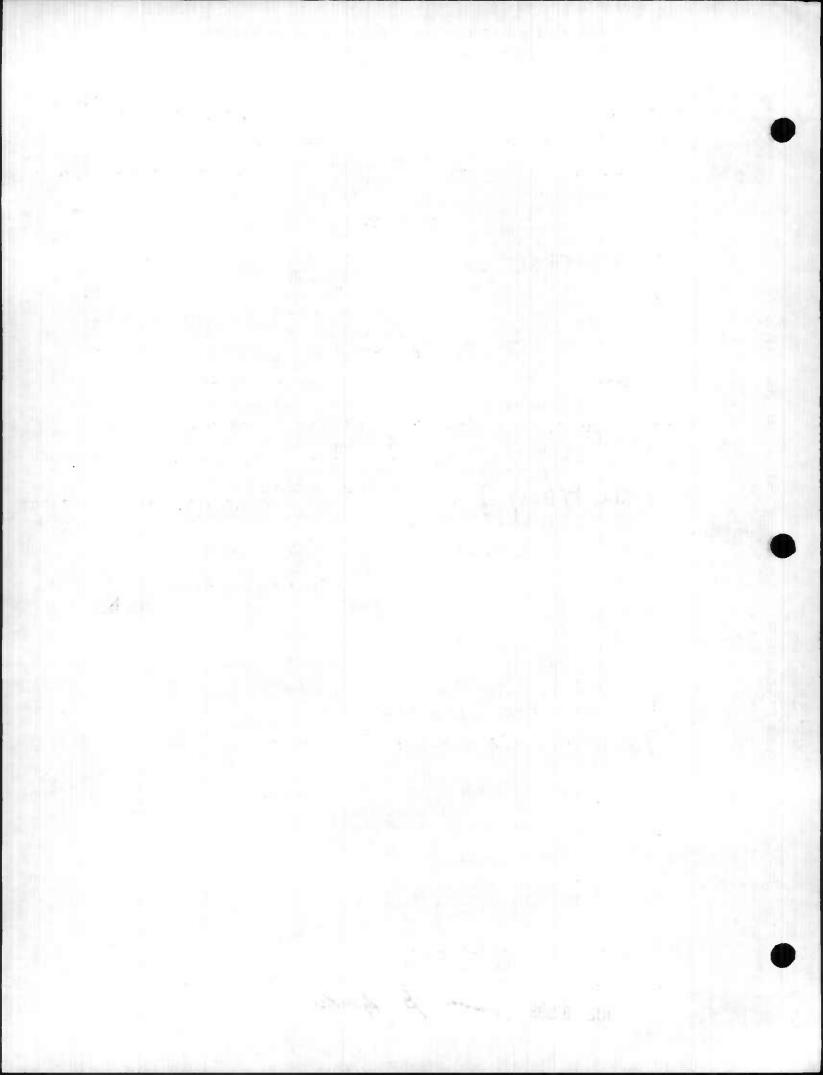
32. Aegistrar's Signature

ARK HEIGHTS AVE BALD MD 21208

28d. Describe how Injury occurred

DHMH 16 Rev 6/95

To the Hospital within 24 hours of To the Funeral Completely filled

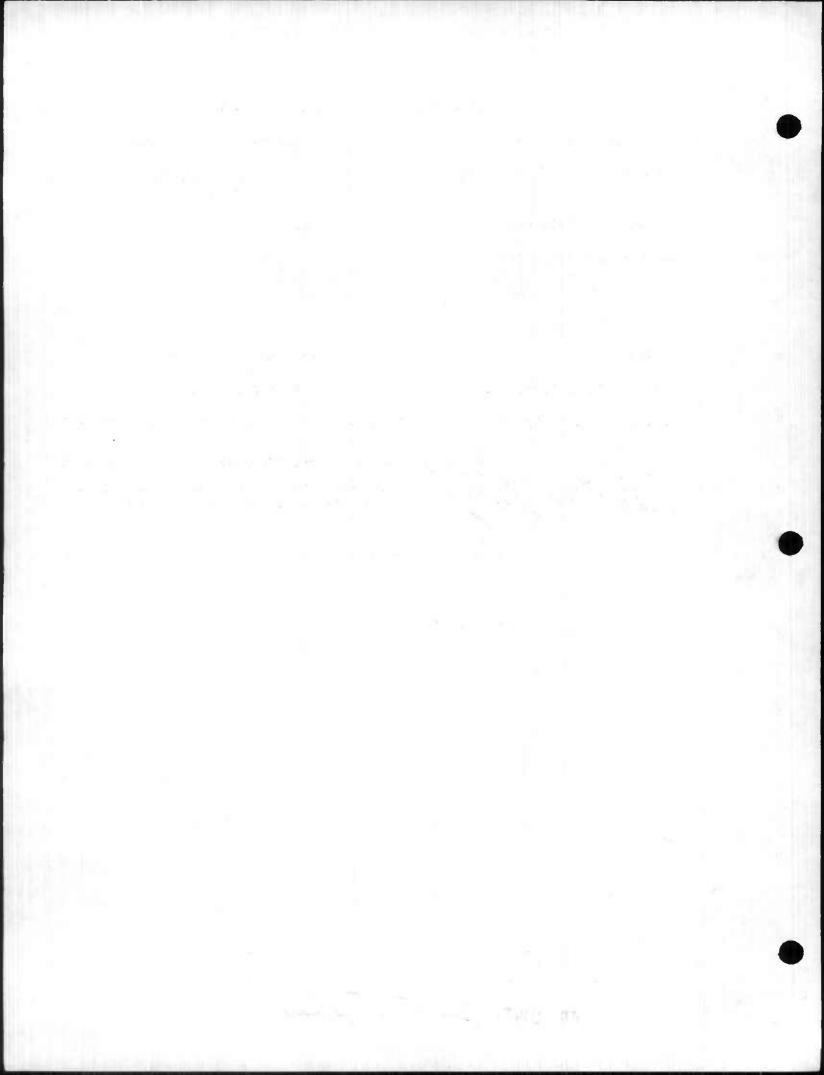


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State of Maryland / Department of Health and Mental Hygiene

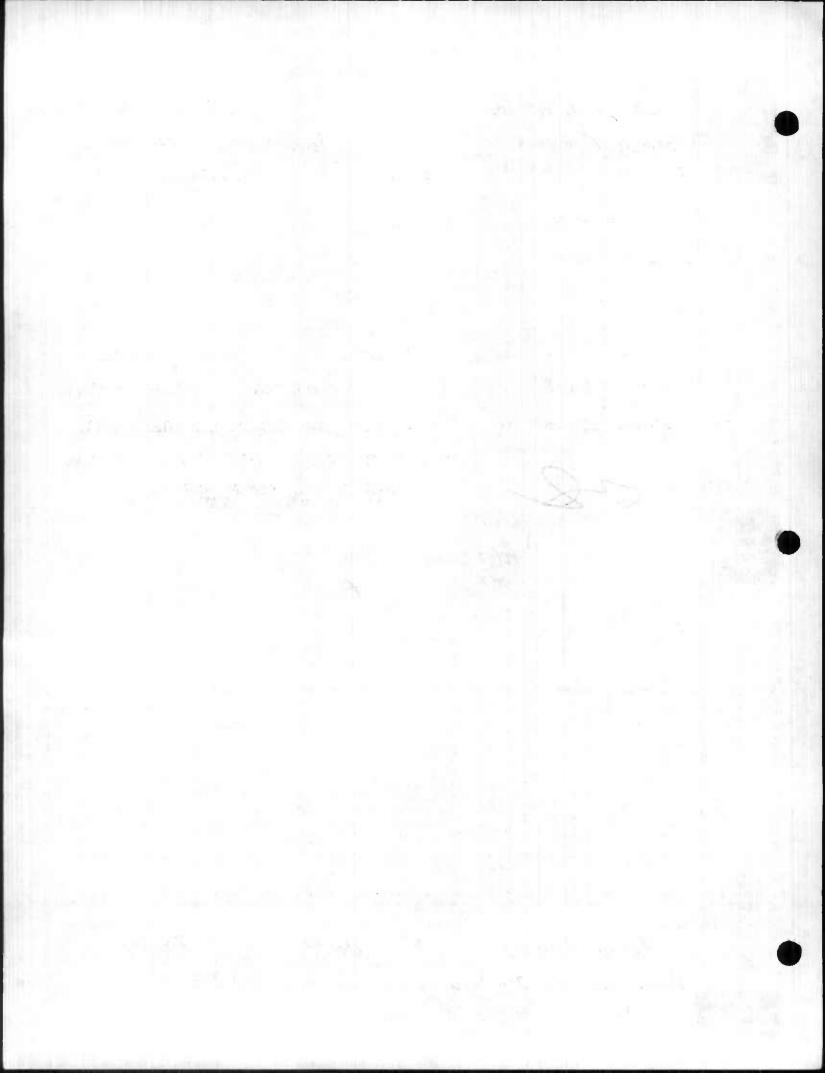
and Mental Hygiene 99 21707

						Ce	rtificate	e of	Death		В	eg. No.			
			1. Decedent's Nama (First, Middle, I	.ast)						1	2. Date of Daar	h		3. Time	e of Death
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	/Medi Examii		4a. Facility Name (If not institution, o			1120710	7 20	9/		vn, or Lo	cation of Death	1	y of Death		. JU AM
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Н	Funeral				ae (In vrs.	last birthdey)	If Undar	1 Yaar			8. Date of Birth	-			ta or Foreign
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	Ne N	ecto		ltimore			T		Dund	alk					03 2 2 110
	No.	늄	10e. Street and Number				10f. Zip	Code				0g. Citizan of	What Cour	try?	
	ath 7	ra .	802 Oakleigh Be	_						1222		Unite			
120	or its	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marriad 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forcas 1 Yes 2 if Yes, Give Year or Datas	?] No		Was Deced If Yes, spec 1 ☐ Yes 2			jin? (Spe , Puerto (cify Yes or No- Rican, etc.)		ce - Americ ack, White, fy:	etc.	
Ö	72 hours "naturel".	8	15. Decedent's		. 44447		dent'e Heus	i Occur	netion			16b. Kind of E	Ruelnose/Inc	Whit	te
21215-0020	and ZIZIS-U be filed within 72 ho ttal Hygiene. d other than "natur event, the Medical	Completed	(Specify only highest g	rade completed)	16a. Decedent's Usual Occupe (Give kind of work done de life. DO NOT use retired)			during most of working		ng	TOD. KING OF E	ousiness/ini	Justry		
212	filed within Hygiene. other than "	E	Elementary/Secondary (0-12) 7 Years	College (1-4o	5+)							Chas	7 T 3		
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Maryland	should be filed within and Mental Hygiene. marked other than imatic event, the M	Be C	William Mickey	Duch Cr									,		
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Ma	d2 s th en 7 is trau		Mrs. Clara L. H				_				oad Du				21222
a,	Healing 2 m 2		20e. Method of Disposition	ugii/wile	20h F	Place of Dispo			JII bea	CII K		20c. Location			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic or once.		1 Burial 2 Cremation 3 4 Donetion 5 Other (Spec	ity)	е 9	emetery, crer	matory or of	ther ple		7/12	/1999				
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			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that caus	the deat	h. Do not ent	er the mode	e of dyi	ng, such as	ardiac o	undalk, r respiratory arm	Mary 1	and	21222 Approxin	mate
-81	Physician		shock, or heart failure. List on	y one cause on each	fine.								į	Interval I Onsat ar	Between nd Death
	/Medical		Immediate Cause (Finai	06.	1		2.	,	6		, .			1.	
1	Examiner		disaase or condition resulting in death)	a.	ons	C	-en	al	P	rs c	ure			ナク	ears
		<u>ه</u>		a Chr	Due to (d	or as a consec	quence of):		6	5					ears ears
	ted nsit	듣		b. Cong				ul	_ /	ar	ure	-		5 4 4	ears
	ertificate be executed ing physician and e as the buriel-transit	Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	1/	Due to (c	or as e consec	quence of):						-	7 -	
68760,	be e ician burie	ai	Cause (Disease or injury	o ALL	ery	ens	on							20) year
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	the e	Physician/	Part ii. Other eignificant conditiona	contributing to death	but not res	ulting In the u	nderlying ca	ause gi	ven in Part I.		23b. Did to	bacco use c	ontribute to	the cau	se of death?
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360	S S CA	mpl											of	death?	
		S									1 □ Ye	s 200No	10	Yes 2	20(No
/it	ysician: The	Be	25. Was case referred to medical examinar?								(Check only on	e)			
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n	ng P	ü	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, D	ury ay Year)	28b. Time of Injury	2	8c. inju Wo	ry at rk?	2	28d. Describe ho	w Injury occu	rred		
.0	ath. r: Aft	ati	2 ☐ Accident investigati	on			М		Yes 2□N	No					
Division	or Attendiate death Director: A	Certification:	3 ☐ Suicida 6 ☐ Could not 4 ☐ Homicide determine	d 200. Placa Ul I	njury - At he	ome, farm, str	eet, factory	, office		2	28f. Location (St City or Town	reet end Num , State)	ber or Rura	/ Routa N	iumber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1X Certifying F	hyeiclan: To the bes	t of my kno	wladge death	occurred a	at the ti	me date and	I nlace a	and due to the or	use(s) and m	se senne	lated	
	To the Hospita within 24 hours To the Funeral completely filled	edical	(Check only 2 Medical Ext	miner: On the basis and manner:	of examina	tion and/or in	vestigation,	In my	opinion, deat	h occurre	ed at the time, d	ate and placa	, and due to	the caue	e(s)
	With To the	Σ	29b. Signature and little of certifier						se number			9d. Date sign			r)
			M. Do	1400-	11	MA		A.	460	27		7/	8/9	9	
			30. Name and address of person who	completed cause of	death (iten	23a) /Tune	Print)	5	100	A	ECLIDA	1/1-	1-	Λ	
			30. Name and address of person who 9105 FRAW 31. Date filed (Month, Day, Year)	KLIN C	9 U AA	2 = 1	?	ZA	とサッル	100	SHINE	MAC	122	7	
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	trans Diana	tura	-	-				. 0 2	123	/	-
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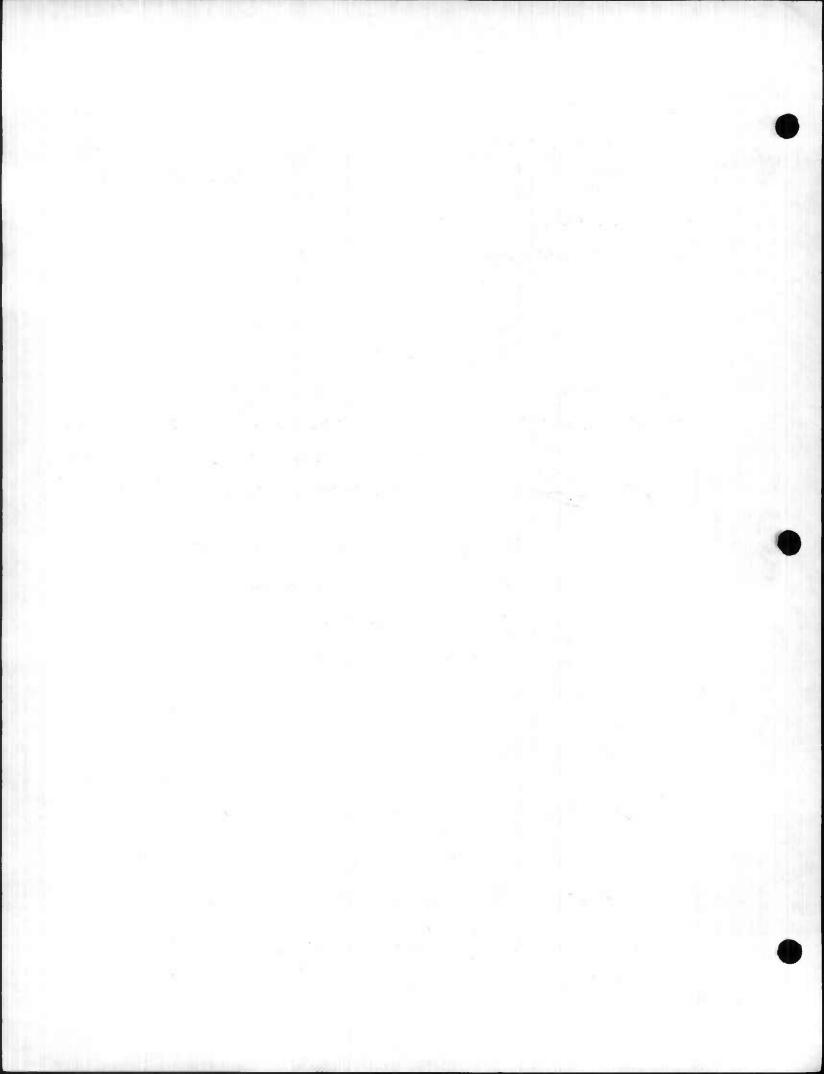
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 2 1 7 0 9

Baltimore, Maryland 21215-0020 permit. Peges 1 and 2 should be filled within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Dependent of Health and Mental Hygiene Inspection of Health Andrew Inspection of Health		Sociel Sacurity Number 6. St.	a street and number) CAP AX M 20 F	ga (In yrs. li	last birthday) 58 Yrs.	If Unde		4b. City, Town, or	2. Data of De Month	Dey	Yuar of Death		i 20pm	
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re, N s 1 end r Health tem 27	2	0e. Mathod of Disposition	J DON	20b. PI	lace of Dispo	sition (Na	ma of		TIMORE,	MARYLAN 20c. Location -		236 vn, Stet	:0	
Peges nent of I		1 XBurial 2 ☐ Crametion 3 ☐ 4 ☐ Donation 5 ☐ Othar (Specific			ematery, crar PLE GR			-	7/10/99 QUEENS, NEW YORK					
Baltimore, N permit. Pages 1 and Deportment of Health Important: If Item 27 any Injury or other tr once.	2	21. Signature of Funeral Sarvice Licenses 22. Nama and Addrass of Fecility									, IVEW	IUr	<i>I</i>	
Balt pemit. Depentimportuany Inj any Inj panse.	CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTO, MD 2123													
Physician	1	 Pert1. Entar tha diseese, or com shock, or haart failure. List only 	olications that caused ona cause on aach li	d the daeth na.	. Do not ent	er the mod	le of dyi	ng, such es cerdia	c or raspiratory a	rrast,		Approxi Intarvai Onset a	lmata i Between and Death	
/Medicai Examiner	Immediata Causa (Final disaasa or condition rasulting in deeth) a. Adeno concoronae, Unknown Primary Due to (or es e consequence of):										9	DAION	Ms	
P.O. Box 68760, \tag{Approx} tat the death certificate be executed by the ettending physician end etached for use as the bunet-transit Physician-Medical Examiner		Sequentially list conditions, any, laading to immadiata ause. Entar Undarlying ause (Diseasa or Injury at Initiated evants esulting In death) Last	b. //alig	Dua to (or	As e consequence as a consequence	quanca of):	Nesi	00						
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

					State of W	aryianu	-	ificate of	Death		Reg. No.	9 2.	1709
в	Physici	an.	1. Decedent'a Nam	a (First, Middle, L	est)					2. Date of Dea Month	nth Day	Yaar	3. Time of Death
	/Medic		FRIDA	QUIN				,		JULY	4]	999	12:10 am
	Examir	er			ve street and number)				4b. City, Town, or Lo	ocation of Death	4c. County	of Death	
					PHIA ROAD				ROSEDAL	E	BALT	IMORE	
	Funeral Director		5. Social Security N 218 32 8	3059	Sex 7. Ag 1□M 2又F	a (In yrs. las	yrs.	If Under 1 Yaar Months Days	If Undar 24 Hrs. Hours Min.	8. Date of Birtl (Month, De) AUG 17	(, Year)	9. Birthpie Count GERMA	aca (Stete or Foreign ny) NY
	show		Usual Residence o 10a. State	10b. County		10c. City,	Town or Loc	ation				10	d. Inside City Limits
	Ba-f	Director	MD	BALTIMOR	E	ROS	EDALE						1 ☐ Yes 2 No
	in the	Dire	10e. Street and Nu					10f. Zip Code			10g. Citizen of V	Vhaf Count	ry?
	9th w	ra	8013 OLD	PHILADEL	PHIA ROAD			2	1237		USA		
21215-0020	ges 1 and 2 should be filed within 72 hours effer deeth with the Meryland it of Health and Mental Hygiene. If Itam 27 is marked other than "natural", or items 23a or 28a-1 show or other traumetic event, the Medical Examiner must be notified at	by Funeral	11. Marifal Status 1 ☐ Never Marr Widowed	ied 2□ Married 4□Divorced	12. Was Dacedant Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		- 11	as Decedent of I Yes, specify Cub	Hispenic Origin? (Sp an, Mexicen, Puerto Specify:	ecify Yas or No- Ricen, efc.)		e - Americe k, Whita, a :: WHI	fc.
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Baltimore,	permit. Peges 1 end 2 Department of Health a Important: If Itam 27 la any injury or other tra once.		21. Signature of Fu	ineral Service Mce	nson			Name and Addre	ess of Facility EDALE FUNI	ERAL HOM	E 1211 C		O AVE MD 21237
			23a. Part T. Emer t	he disease, or con	plications that caused one cause on each li	the death.	Do not ente	the mode of dyi	ng, such as cerdiac	or respiratory ar		riords,	Approximate Interval Between
	Physician /Medicai Examiner	35	Immediete Cause disaasa or condition rasulting in death)	(Final n	Λ	Due to (or a	as a consequ	ence of):	SPRT PA				Onsat and Death
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Divisi	To the Hospital or Attending Phwithin 24 hours efter death. To the Funeral Director: After this completely filled in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not l determined		ury - At hom c. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Tow	Straet and Numb m, Stete)	er or Rural	Routa Number,
	e Hospi n 24 hou e Funer letely fill	edicai	29a. Certifier (Check only one)	1 Certifying Pi 2 Medical Exa	nyalclan: To the best miner: On the basis of and manner st	exeminetio	edge, death n and/or inve	occurred et fhe ti estigation, in my	me, dete end piace, opinion, death occur	and due to the d red at the time,	cause(s) and ma date and plece,	nner as sta and due to	ated. the cause(s)
	withir To th	M	29b. Signature and	title of certifier	A A 4	െ		29c. Licens	se number	T	29d. Date signe	d (Month, L	Pay, Year)
	,		Saha	il Mr	stela (Jan	MD	D-4	8025		7-1	5-9	9
	5		30. Neme and addr	ess of person who	completed cause of d	leath (item 2	(Type, P	rint) A	ROSDA	LE, MD	2123	7	*
	Sta	_	31. Dete filed (Mon	th, Dey, Year)		ar's Signatui							
	Registr	ar	1111 0	9 1000	he lee	1.							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death 3:55AM AI Ruth Smedley Rolston 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Doctors Hospital Prince Georges Lanham If Under 24 Hrs. 5. Sociel Security Number 7. Age (In vrs. lest birthday) If Under 1 Yeer 6. Sex 8. Date of Birth (Month, Day, Year) Birthpiece (State or Foreign Country) 1 M 2 F Months Devs Hours Min Yrs. 85 1914 Pennsylvania 563-40-9456 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Prince Georges Bowie 10e Street and Number 10f. Zip Code 10g. Citizen of Whel Country? 20720 USA 4309 Fruitwood Court 11. Meritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ 12 Executive Administrator US Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Mabel Tracy Frederick L. Smedley 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Ann Hacia(Daughter) 4309 Fruitwood Court, Bowie, MD 20720 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 07/07 Metro Crematory Baltimore, MD 21. Signature # Funerel Service Licen 22. Neme end Address of Fecility Hardesty Funeral Home, P.A. nomas 12 Ridgely Avenue, Annapolis, MD 21401 of enter the mode of dying, such as cardiac or respiratory errest, 23a. Peri1. Enter the disease, or complications that caused the death shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onsel end Death Immediate Cause (Final disease or condition resulting in death) to (or es e consequence of): Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were eutopsy findings evalleble prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 No 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA 27. Menner of Death Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

P.O. Box 68760, Division of Vital Records,

or Attending Physician: The law requires that the death certificate be executed the buriel-transit ettending physiclan for use as the burie signed by page 2 should be certificate hes director, this After death. efter death 6 To the Hospital o within 24 hours of To the Funeral D

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Pages 1 and 2 Department of Health a Important: If Nem 27 Is any injury or other tra

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Certification:

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29a. Certifier (Check only one)

State Registrar

31. Dete filed (Month, Day, Year) 9 1999

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29b. Signeture end title of certifie

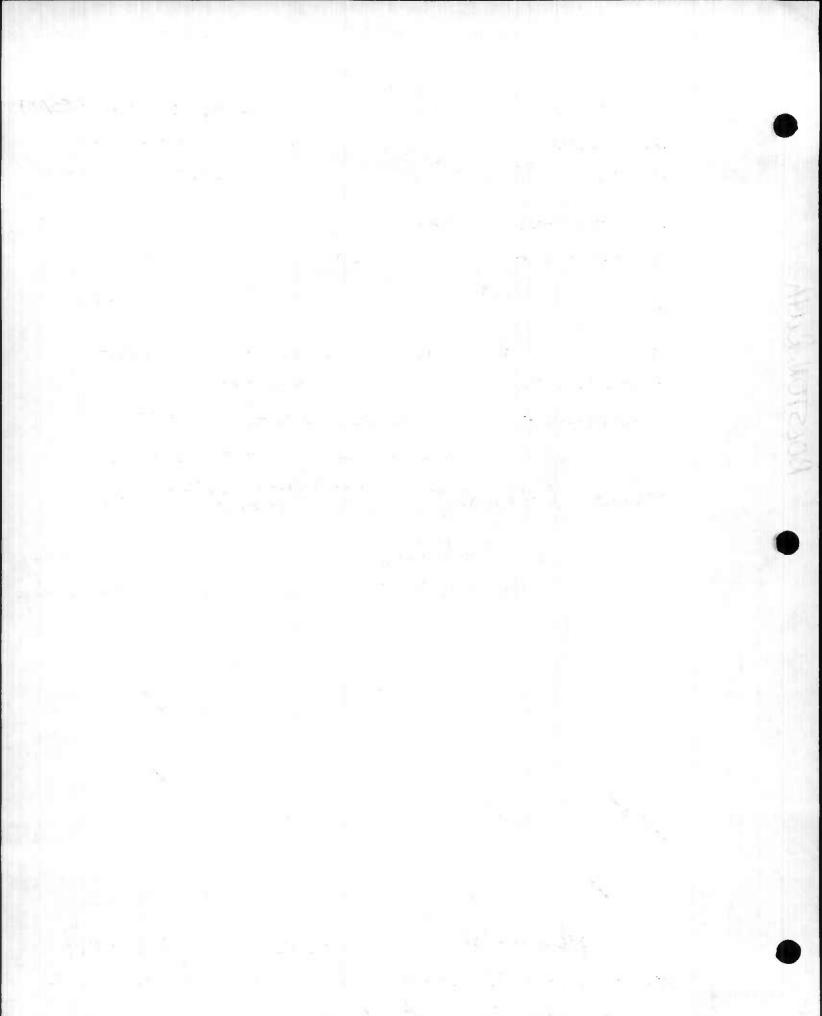
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MOBARAK KARIM, 7610 CARROLL AVE, TAKOMA PARK, MD 20912 32. Registrer's Signeture

15 Certifying Phyelofan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated.
2 Medicat Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, dete and plece, and due to the cause(s) end menner stated.

29c. License number

29d. Dete signed (Month, Dev. Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time f Deth July Doris Todd Roberts 1999 9:30 am 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Odenton Anne Arundel 1349 Meyers Station Road | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 18,1908 6. Sex 1 ☐ M 2 💢 F 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 7. Age (In yrs. last birthday) Yrs. 90 578-03-5908 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1349 Myers Station Road 21113 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Lest) 18. Mother's Neme (First, Middle, Melden Sumeme) Wesley Taylor Ann Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Ronald Roberts (Grandson) 493 King Malcolm Avenue, Odenton, MD 21113 20b. Piece of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery 20a. Method of Disposition 20c. Location - City or Town, State ND Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 07/08 Suitland, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heer feilure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of). n/Coces Due to (or es e consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Was an autopsy performed? 1 □ Yes 2 □ No

Physician /Medical Examiner

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To the Hospital or Attending Physician: within 24 hours after death.

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Division of Vital

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tem 27 is marked other than "natural", or items 23e or 28e-f show other treumatic event, it a Medical Examiner mant on notified at

al Hygiene.

permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other treumatic event.

the Maryland

Baltimore, Maryland 21215-0020

Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical

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25. Wes cese referred to medical examiner? 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigation 2 Accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier

3 Suicide

4 | Homicide

1 Certifying Phyaician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 Could not be

29c. License number

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day,

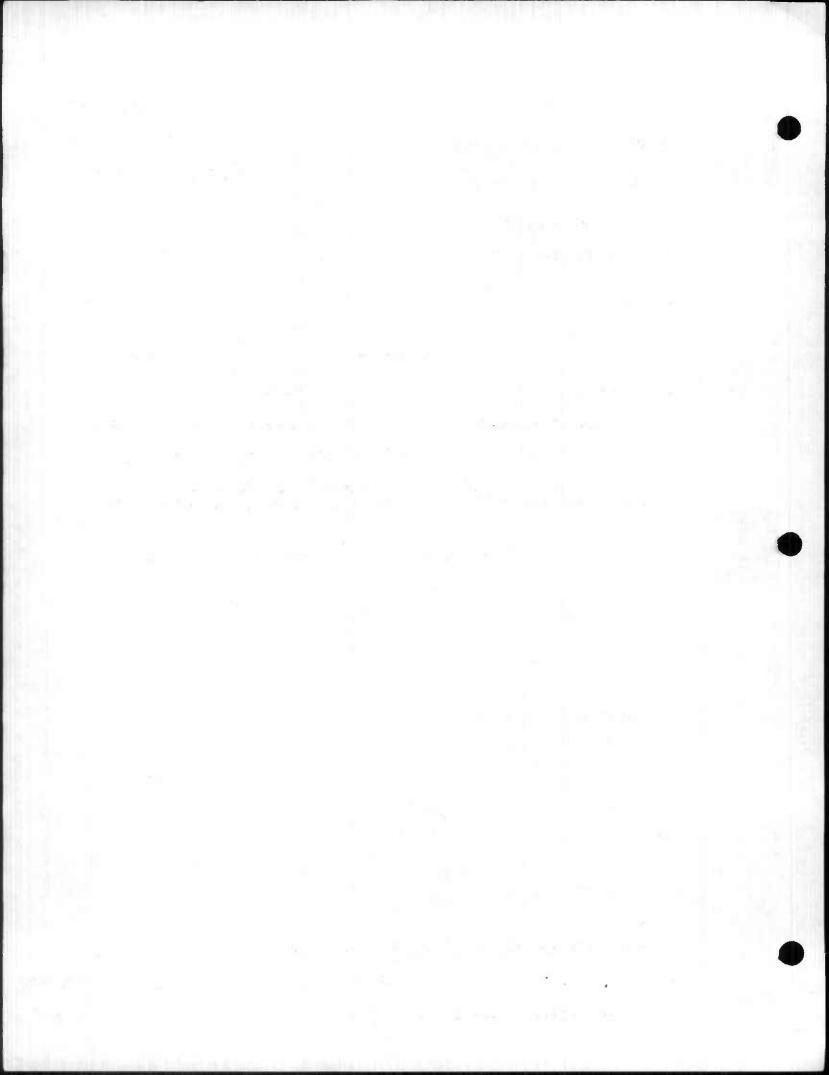
9 1999

32. Registrar's Signature

State Registrar

DHMH 16 Rev 6/95

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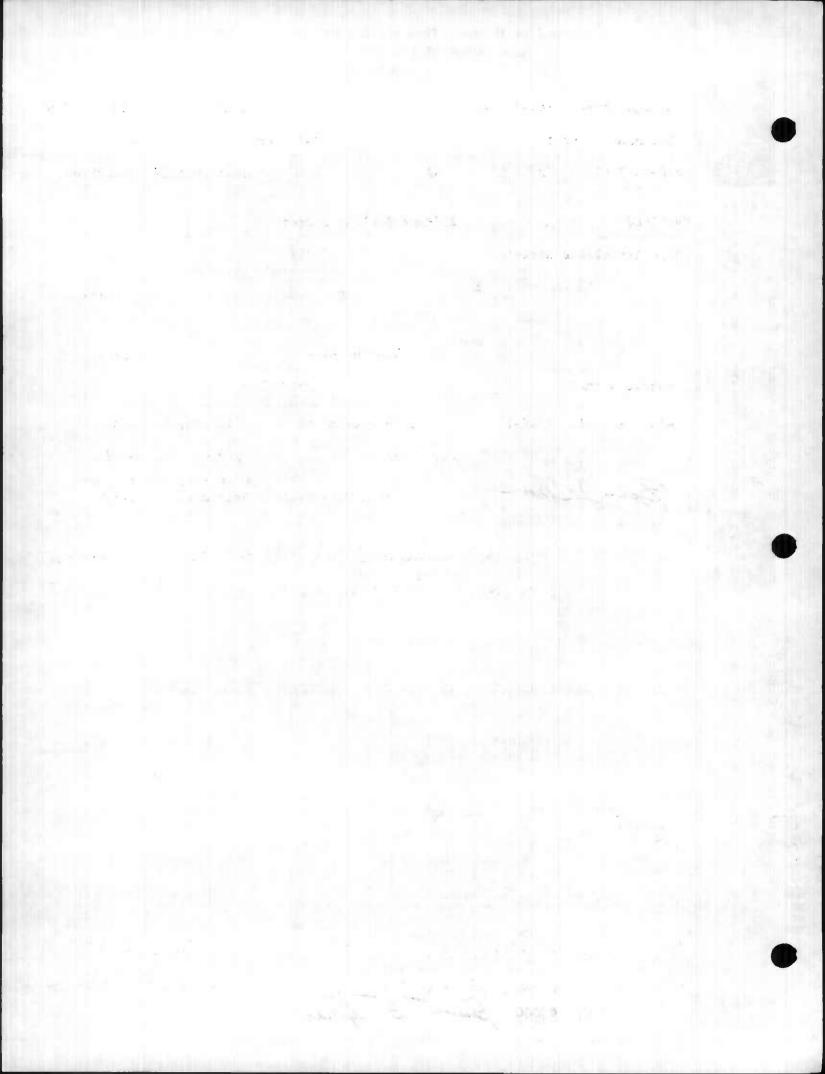


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dev Vooi **Physician** George Edward Rickels Sr. 8 1999 8:30 AM JULY /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner St. Agnes Hospital Baltimore NA If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1₩ 2□F Months Days Hours Yrs 216-34-7157 62 Director June 19,1937 Maryland Usual Residence of Deceden with the Maryland 10d. Inside City Limits 10a State 10b Counts 10c. City. Town or Location r 28a-f show 1 N Yes 2 No Directo Maryland NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or itams 23a or it may higher or other traumatic event, the Medical Examiner must be in once. 3350 Strickland Street 21229 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Dates: 14. Rece - American Indian, Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Longshoreman Shiping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Robert Rickels Mary Ikel 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Rickels (Wife) 3350 Strickland St. Baltimore, Md 21229 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Fort Lincoln 7/10/99 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, MD 21229 23a. Part1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** immediate Ceuse (Final disease or condition resulting in deeth) /Medical ocute myocoro intarction Examiner Due to (or as a consequenca of) Physician/Medical Examiner Calanory 05 272 physician and s the burlat-trans Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or es e consequenca of): thet initiated events Due to (or es a consequenca of) resulting in death) Lest 2 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 2 1 Yes 2 No 3 Probably 4 Unknown 3 à 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of deeth? Has 9090 1□ Yes 21No 1 ☐ Yes 2 ☐ No NAMEGREDIONE Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient → ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2K No 2 this 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred Certification: Naturel 2 Accident 5 Pending Investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Ber 4 Homicide ŏ Cartiflier
Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, and due to the cause(s) and menner as steted.

Check and 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) and manner stated. edical 29s. Certifier 2 To the Within 2 To the 29d. Dete signed (Month, Day, Year) 29b. Signeture end fittle of certifier 29c. License number M Name and address of person who completed cause of deeth (Item 23a) (Type, Print) rolt DUND 20 1./Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Deta of Deeth 3. Time of Death Mice 5:50 AM Sundberg 26 4e Facility Neme (If not institution, giva street and number) 4b. Clty, Town, or Location of Deeth 4c. County of Deeth Park Place Baltinore Baltinare Roland MO If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Days Hours Min. Mooth, Day (2.27) 5. Social Sacurity Number 6. Sax 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) T Uwa 10 M 2 F Months 88 Yrs. 215-38-6032 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 40th Ct 830 W. 21211 115 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14 Rece - American Indian Black, Whita, etc. 1 Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Nurse Medical 18. Mother's Nema (First, Middle, Meiden Sumeme) 17. Fether's Nema (First, Middle, Last) Cocalia Revella Sundberd Albert E. 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) unknown 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 Burlai 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. 22. Name end Address of Fecility Wade Director State Anatomy Board, 655 W. Baltimore Street Une Baltimore, MD 21201 23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, back, or heart fellure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final As pivate nous disease or condition resulting in deeth) Accident ensprivosalan Due to (or es e consequence of) Fibrillat ears Atrial

Physician /Medicai Examiner

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Division of Vital Records, P.O. Box 68760,

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permit. Peges 1 and 2 should be filed within 72 hours efter death with the Manylen Department of Heelih and Mental Hygiens. Important: if item 27 is marked other than "naturel", or items 23e or 28e-1 show any injury or other treumatic event, the Madical Example manifest and any injury or other treumatic event, the Madical Example manifest and any injury or other treumatic event, the Madical Example manifest.

Baltimore, Maryland 21215-0020

Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Lest by Physician/Medical

Due to (or es e consequence of):

Pert II. Other signiticant conditions contributing to death but not resulting in the underlying cause given in Pert I. Venous Ostourthis

23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 2 No 3 Probably 4 Unknown

24a. Was en eutopsy performed?

24b. Were autopsy findings eveilable prior to completion of cause of death?

1 Yes 2 No 26. Place of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical exeminer? 1 Yes 2 No 27. Menner of Death

5 Pending

6 Could not be determined

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1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) investigation

28b. Time of

Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) 28c. Injury et Work? 1 Yas 2 No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Routa Number, City or Town, State) 1/2 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and manner as stated.

(Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated. 29b. Signetura end titla of certifier

29a. Certifier

1 Naturel

2 Accidant

3 Sulcide

4 Homicide

29c. Licansa number 037133

#209

29d. Dete signed (Month, Dey, Year) 6/30/1999

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Dunc L. Duw M.D. +600 Osla Dine

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Towson MD 21204

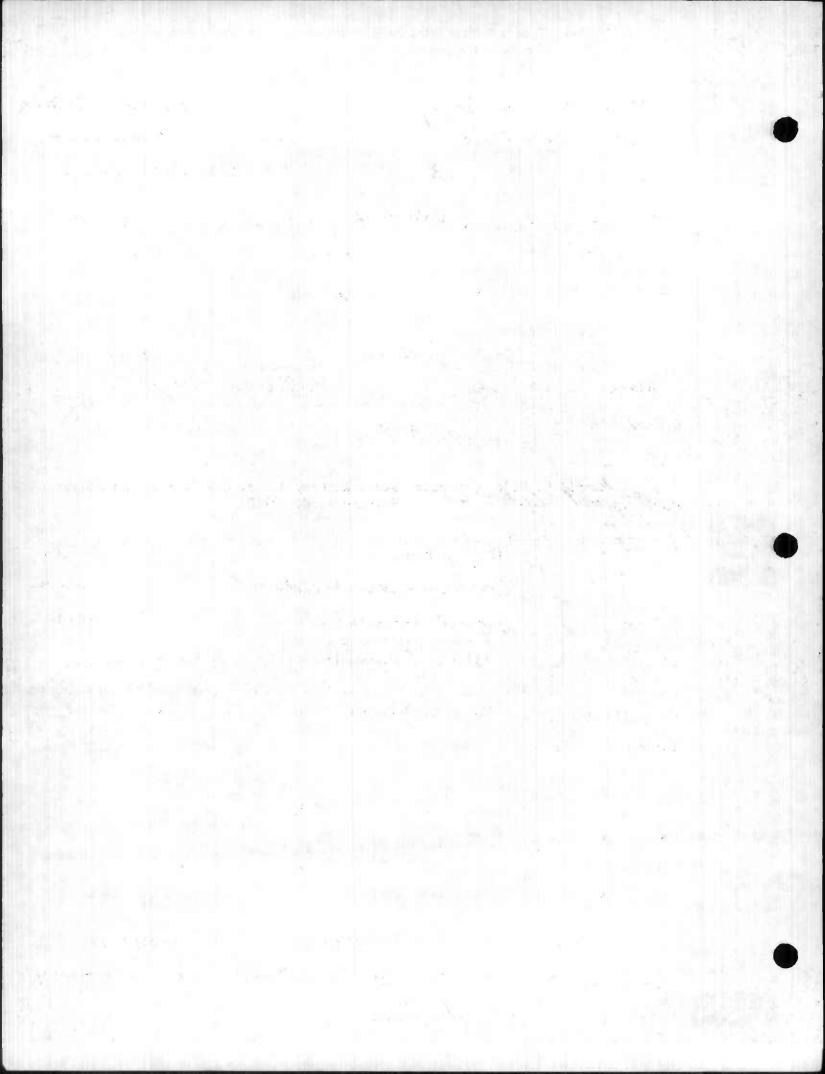
Registrar

31. Dete filed (Month, Day, Yeer) 0 9 1999

32. Registrer's Signeture

Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifics

To the Hosp within 24 hor To the Fune complately fi



WRC 99-3248-005 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. UNK. 99-128 State of Maryland / Department of Health and Mental Hygiene Raymond Farrell Sears Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** JUNE 08, 1999 Raymond Farrell Sears 4:40 PM. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2617 YORKWAY Dundalk
If Under 24 Hrs Baltimore If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 10 M 20 F Yrs. 40 March 27,1959 unknown Director unknown Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d Inside City Limits a Pos the Maryla 1 ☐ Yes 2 ₺ No Director 28a-f Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 2955 Cornwall Road 21222 unknown Berns 23a Funeral 11. Marital Slatusunknown Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 8 1 Yes 2 No Specify: Specify: white 3 3 ☐ Widowed 4 ☐ Divorced 'natural', unknown Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Nama (First, Middle, Last) Be Pages 1 and 2 should be nant of Health and Mental int: If less 27 is marked or unknown unknown 19a, Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If ham 27 is any injury or other trac once. unknown unknown 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☑ Other (Specify) in state 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore St. 21. Signature of Fuperal Service I Wade, Ronald S Director war 21201 Baltimore, MD Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bock, or heart failure. List only one cause on each line. Approximate Onset and Death **Physician** /Medical Immediate Cause (Final Narcotic intoxication disease or condition resulting in death) Examine Due to (or as a consequence of): Examiner the death certificate be executed and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the th Due to (or as a consequence of): 980 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yae 2 No 3 Probably 4 Unknown signed b þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 Yes 2□ No Physician: Be 25. Was casa referred to medical axaminer? 26. Place of Death (Check only one) AT Other: 4 Nursing Home 5 Residence (Specify) 1X Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this SCENE funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) After or Attending 1 Natural 5 Pending 1 ☐ Yes 2√2 No death. Found: 6-8-99 investigation Unk. 2 Accident Unknown 24 hours after deal Funeral Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in Unknown Unknown Hospital 29a, Certifier 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated edical completely 22 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 8

State

0 9 1999 Registrar

31. Date filed (Month, Day, Year)

29b. Signa

we and little of certifie

WP LO CHE 32. Registrar's Signature

W

and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

Box 68760.

PO

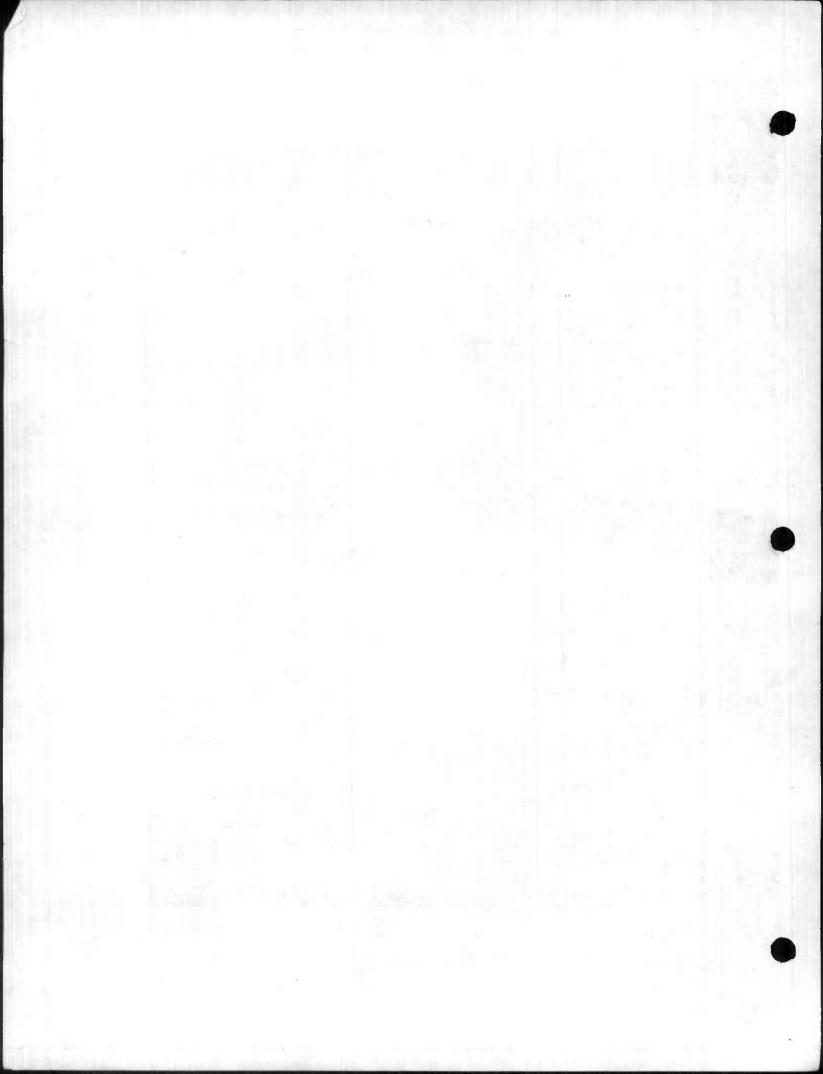
Records.

Division of Vital

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year) JUNE 09, 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		Certifica	te of Death	Reg	. No. 9 9	21/15
1. Decedent's Name (First, Manysician	Stith	UR.		2. Date of Death Month JULY 6	Dey 1999 Yea	3. Time of Death 1120 AM
ter HARBOR HOSPI		1/2	4b. City, Town, or BALT IMOR	Location of Death	4c. County of De	path O
5 Social Security Number	7 10PM 20 F 7	(last birthday) If Und Month	er 1 Year If Under 24 Hrs s Deys Hours Min.		ear) 922 9.8	hirthplace (State or Foreign Country)
Usual Residence of Deceden 10a. Stete 10b. Cou		ity, Town or Location	2			10d. Inside City Limits
10e. Street and Number 504 000 11. Marital Status 1 Never Married 2001	lgeview	101. 2	ap Code 21885	109	Cilizen of What (Country?
3 □ Widowed 4 □ Divor	M Yes Give	100-0-100	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - An Black, Wi Specify:	nerican Indien, nite, etc.
	dent's Education whest grade completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of s life. DO NOT Cenera)	vork done during most of wo use retired)	ninistrator	b. Kind of Busines	rnment
17. Father's Neme (First, Mide	J. Stith	DY.		me (First, Middle, Ma	iden Sumeme)	
19a. tnforment's Neme/Relati	onship (Type, Print) + i + h - (1) i FP,	19b. Mailing Addre	as (Street and Number or Ri		City or Town, State	a 1325
	on 3 Removel from State	Place of Disposition (N	ame of other place)	Date 20	c. Location - City	
4 Donation 5 Othe 21. Signature of Furniral Serv		(1/150/) /-(22 Name	and Address of Facility	Cinecol	Wings 11.	PA.
Jerror 23a. Part Differ the disease	or complications that caused the dea	1 348	Fred hillen	Pass, Bi	alfor, n	Approximate
Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undervise.	Due to	or as a consequence of or es e consequence of		sease		
Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequence of):	-		
Part II. Other significant cond	litions contributing to death but not re	sulting in the underlying	cause given in Pert I.	23b. Did tobe	icco une contribu	Ite to the cause of death
Part II. Other significant cond				1 🗆 Yes	2 No 3	Probably 4 Unknow
Completed by				24a. Was an a performe INSPECT	d?	b. Were eutopsy tindings available prior to completion of cause of deeth?
				1 ☐ Yes	2 XX 40	1 ☐ Yes 2 ☐ No
25. Was case referred to med axaminer? XXYes 2 No	Hospital:	☐ ER/Outpatient 3☐ I	Other	eth (Check only one) Home 5 Residence	ce 6 ☐Other (Sp	Decity)
27. Manner of Death XXNeturat 5 Per 2 Accident	28a. Dete of Injury (Month, Day Year) stigetion and not be	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how		
4 Homicide	28e. Plece of Injury - At I building, etc. (Special Injury - At I building, etc.)	nome, ferm, street, fectority)	ory, office	281. Location (Stree City or Town, S	et and Number or State)	Rural Route Number,
29a. Certifier 1 Certifier (Check only one)	ying Physician: To the best of my kn al Examiner: On the basis of examin and manner steled.	owledge, death occurre etion end/or investigation	d at the time, date and place on, in my opinion, death occu	e, end due to the caus urred at the time, date	se(s) and manner and plece, and d	as steted. lue to the cause(s)
29b. Signature and title of cert	E breight		9c. License number O.C.M.E.		Date signed (Mo	
30. Name and address of pers	on who completed cause of death (Ite crell M.D. 111		et, Baltimore	e, Maryland	1 21201	
State 31. Date filed (Month, Day, Ye			.//	-		

DHMH 16 Rev 6/95

ORIGINAL

Funeral

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r then "natural", or hema 23a or 28a-f ahov tre Medical Examiner must be notified at

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death

filed within 72 hours after Hygiene.

i. Pages 1 and 2 should be filled wi tment of Health and Mental Hygien tant: If from 27 is marked other the jury or other traumatic event, the

permit. Pages Department of Important: If It any Injury or o

Physician /Medical

Examiner

physician and the burial-transit

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After this funeral

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filled in

completely

The law requires that the death certificate be executed

Records, P.O. Box 68760,

Division of Vital

Physician:

or Attending

death.

To the Hospital or Attend within 24 hours after deatl To the Funeral Director:

Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month Year **Physician** 0652 AM Lydia A. Smith JULY 6. 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS HOSPITAL BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Deys Months Hours 1 M 2 X F 219-22-5933 85 1913 Oct. 20, Germany Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Md. N/A Baltimore City 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6116 Eastern Parkway 21206 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S Armed Forces? 14. Raca - American Indien, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No 1 Never Married 2 Married 1 Yes 2 No Specify: Specify. by 3 X Widowed 4 ☐ Divorced White Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17 Father's Neme (First Middle Last) 18 Mother's Name (First Middle Maiden Sumama) Be (Not Known) Werner Not Known 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) KeithC. Bittner (Grandson) 6116Eastern Parkway Baltimore, Maryland 21206 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, State Date 1 Buriel 2 Cremation 3 Removal from State 7/9/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 21. Signeture of Funeral Service Licensee Milton J Knight Jr 22. Name end Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 23a. Pert1. Enter the disease, of complications that mused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause of each line. Approximate Interval Between Onset and Deeth Immediate Cause (Fine) disease or condition resulting in death) • Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequença of) Physician/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Type 2 No 3 Probably 4 Unknown DEMENTIA AND UROSEPSIS þ 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24e. Wes an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1XXYes 2□ No 1 Inpatient 2 NevOutpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? Vatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Placa of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the cause(s) and menner as stated.

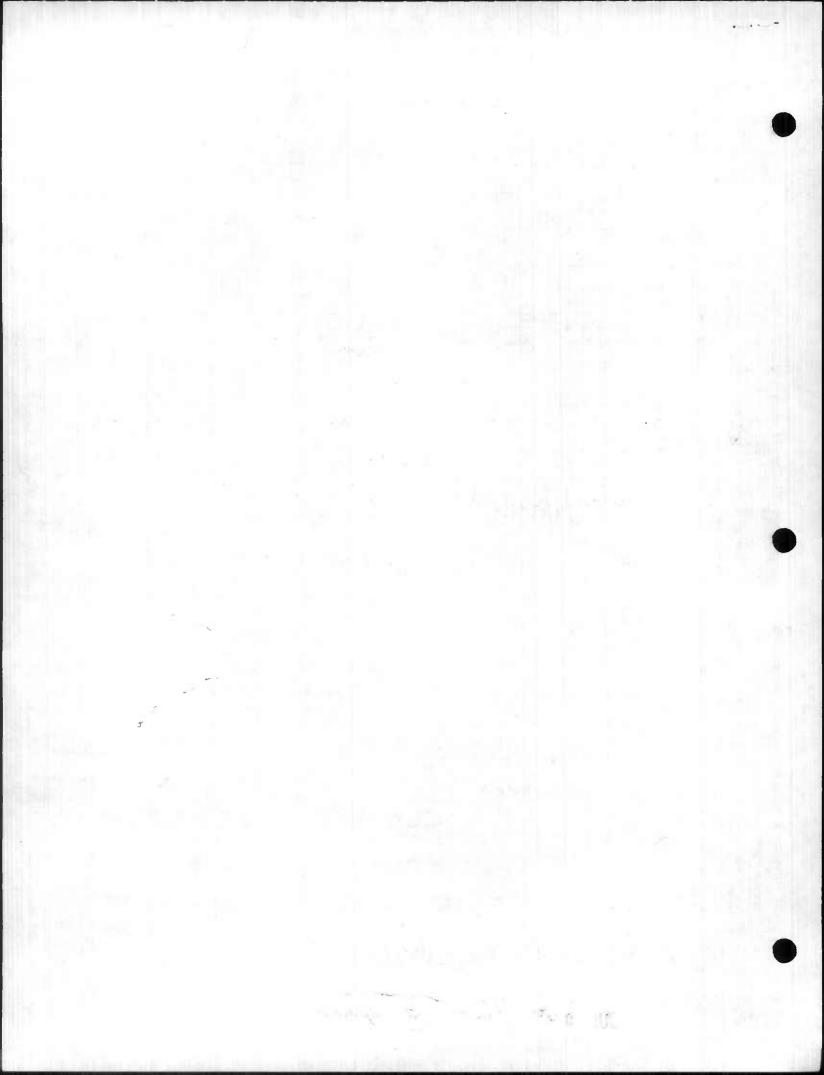
**Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) JULY 8, 1999 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Dey, Year)

32/Fegistrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'e Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day July 5, 1999 **Physician** Walter W. Swords, Sr. 5:20 pm /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Mariner Health of Glen Burnie Glen Burnie, MD If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Days M 2□ F Hours 275-12-3463 81 Director April 12, 1918 Chio Usual Residence of Decedent 10a. Stafa 10c. City, Town or Location 10b. County 10d. Inside City Limits must be notified at MD NA Baltimore City Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1312 Towson Street 21230 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 X No Specify: White Specify. þ XX Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Painter Home Improvement 10 0 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) i. Pages 1 and 2 should be fill then of Health end Mentel Hrant: If frem 27 is marked oth furry or other traumatic even furry or other traumatic even Adam Swords Susan Howe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Walter W. Swords, Jr. 640 Dover Road, Pasadena Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removel from State Department important: If eny injury or Cedar Hill Cemetery July 8, 1999 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deet **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner 10 Sequentially list conditions, if erry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Physician/Medical Due to (or as e consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown PV 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 No GASTRIC 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 452 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The lew requires that the death certificate be assected Box 68760, Records, P.O. of Vital

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Baitimore, Maryland

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tal or Attanding Physician: Tra after deeth.

si Director: After this certificat ied in by the funeral director, pu Division To the Hospital o within 24 hours af To the Funeral D completely filled in

> State Registrar

edical

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year) JUL 0 9 1999

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29b. Signature and title of certified

2 a

30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 4710 22. Registrar's Signatury

miner: On the basis of exa and manner stated.

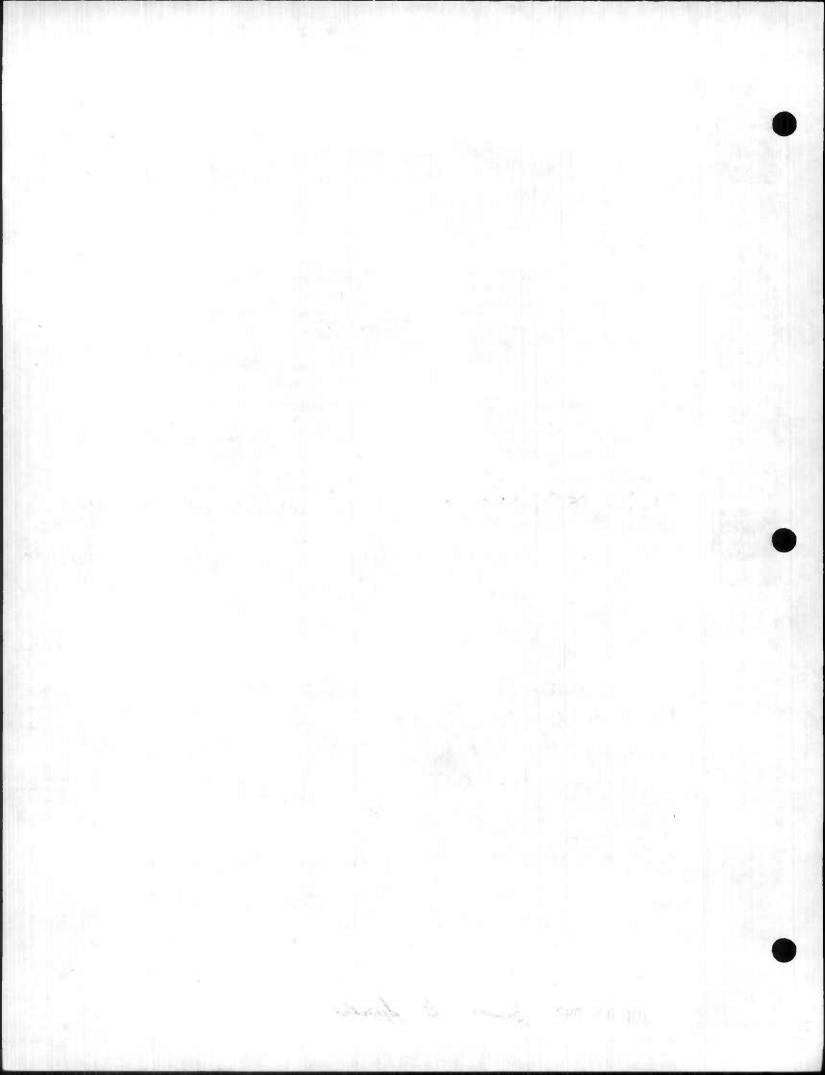
ennington A

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s)

DO251

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEMS 17 & 18 PER FH G773 7/9/99 AH Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Smith S. Frederick 02:57 1999 5, July 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Rockville MD Montgomery Shady Grove Adventist Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Days Hours XXM 2 F 77 Yrs. 1922 Scotland 230-12-2535 Oct. 22, Usuai Residence of Decedent 10b. Count 10c. City, Town or Location 10d. Inside City Limits 10e. State Wellsville Columbiana OH 11 Yes 2□ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 43968 USA 218 3 8th Street # 2 14. Raca - American Indien, Bieck, White, etc. 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Unk. Yes 2 □ No If Yes, Give 1 □ Never Married 2 □ Married White 1 Yes 2€ No Specify: Specify: 3 Widowed 4 Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondery (0-12) Construction 12 0 Laborer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Cruikshank William Elsie Smith 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
12942 Alderleaf Drive, Germantown Maryland 20874 19a. informant's Name/Relationship (Type, Print) Daughter Tammy L. Smith / 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 8, 1999 Wellsville, OH Springhill Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc. 21. Signature of Funeral Service Licansee Victor P. Doda, Jr. 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximate interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Hour 1 Acute Myocardial Infarction Due to (or as a consequence of) Years Coronary Artery Disease Due to (or as e consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 15Yss 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to 24e. Wes an eulopsy

Physician /Medical Examiner

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After this uneral

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24 hours after deal Funeral Director:

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P.O.

Records.

Division of Vital

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at

other traumatic event,

permit. Pages 1 end 2 sh Department of Health end Important: If item 27 Is m any Injury or other traum page.

Director

Funeral

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Completed

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To

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Physician/Medical

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To

Certification:

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death

2 should be filed within 72 hours effer and Mental Hygiene.

Is marked other than "natural", or the

altimore, Maryland 21215-0020

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last

Pert ii. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert i.

completion of cause of death?

1 Yes 2 No 26. Piece of Death (Check only one)

1 ☐ Yes 2 No

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient XIXER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated.

290. Signature and title of cartifie

25. Was case referred to medical examiner?

5 Pending investigation

6 Could not be determined

1 Yes 2 No

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

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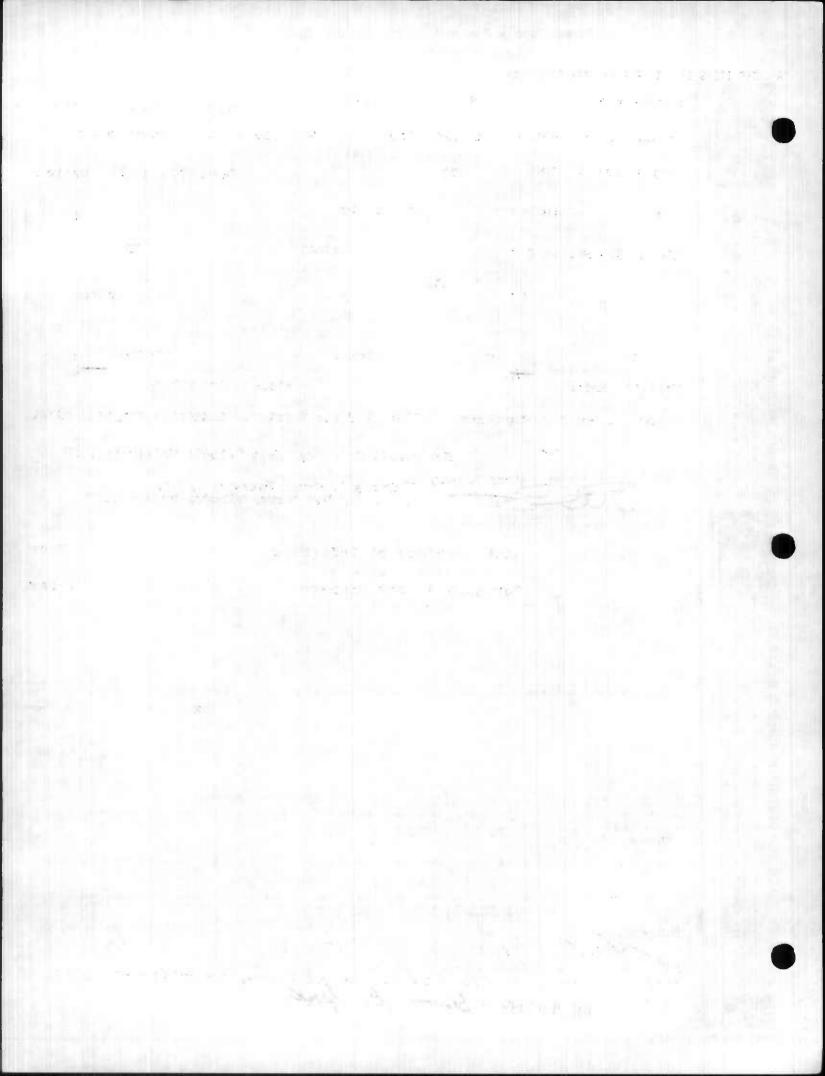
29c. License number

29d. Date signed (Month, Day, Year)

mon who completed cause of death (Item 23e) (Type, Print) 9901 Medical Center Drive, Rockville MD 20850 MD Srour,

State Registrar

31. Date filed (Month, Dey, Year) 0 9 1988. Registre Signature



## Facility Name (if not institution, give street and number) Stella Maris Stella Ma		1.	Decedent's Na	ma (First, Middl	la, Last)			08	unca	te oi	Death	2.	Date of Dea			3. T	me of Death
Scella Maris Sc													uly	y 4th, 1999 7:			7:30 F
Security Number Country Countr	er	40			n, giva sı	treet and num	nber)								ty of Deal	th	
100. Sirelate and Variable 100. Carly From et Location 100. Carly Code 100. Carlo Carlo 100. Packed Carly 100. Carlo Carlo 100. Packed Carly 100. Carlo Carlo rlo Carlo C			Social Security 212-02-	Number 4537							If Under 24 h	irs. 8.	Data of Birti (Month, Day	h v. Year)	9. Birt Co KO	thplaca (Sountry) Cea	Stata or Fore
MD N/A Baltimore 10x. Spread and Number 10x. Method of Lopacion 10x. Method of Lopacion 10x. Method of Lopacion 10x. Spread and Spread and Number or Rural Route Number. City or Town. State. Zpr. Code) 10x. Method of Lopacion 10x. Lopacion 10x. Lopacion 10x. Lopacion 10x. Lopacion 10x. Lopacion 10x. Lopacion 10x. Lopacion 10x. Lopacion 10x. Lopacion 10x. Lopacion 10x. Lopacion 10x. Lopacion 10x. Lo							10c. (City, Town or L	ocation							10d. fns	ide City Lim
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Mary Catherine Shaw 07 08 1999 4 a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlestown Care Center Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth Months | Days | Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) Funeral Months Days 10 M 20 F 215 22 4791 09 Director MD 91 Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 28s-f show the Maryla 1 Nas 2 No Director Md Baltimore Catonsville 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 621 H H the Medical Examiner must be or 719 Maiden Choice Lane Apt BR 21228 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. flied within 72 hours after 1 ☐ Yas 2 ♣ No 1 Nevar Married 2 Married Specify: white Baltimore, Maryland 21215-0020 1 Yes 3€ No Specify: à 3 ☐ Widowed 4 ☐ Divorced Year or Datas: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiere. Wher then College (1-4or 5+) Elementary/Secondary (0-12) Teacher 12 Education 4 permit. Pages 1 and 2 should be file Department of Health and Mertal Hy Important: If then 27 is marked othe any injury or other treumatic event 18. Mother's Name (First, Middle, Maiden Sumema) 17. Father's Nema (First, Middle, Last) 96 Wilbur Shaw Florence Edmonds 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alice Damico/Sister 92 Thomcrest Lane Naples, F134113 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematery, crematory or other place) 20c. Location - City or Town, Stata Data to Burial 2 ☐ Cremation 3 ☐ Removal from Stata Lorraine Park Cemetery 7/12 Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Figneral Service Licente 22. Nama and Address of Facility Sterling Ashton Schwab Funeral Home, Yeter. 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show for heart failura. List only one cause on each line. Balto, 21228 Interval Batween Onset and Death **Physician** /Medical Immediate Cause (Final Kower BSTRUCTION disease or condition rasulting in death) WEEK Examiner Dua to (or as a consequence of) Examiner burial-transit that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last and Dua to (or as a consequence of): physician a s the burial-Box 68760. Physician/Medical Dua to (or as a consequence of) 88 987 23b. Did tobacco use contribute to the cause of death? Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. Records, P.O. 2 1 Yes 2 No 3 Probably 4 2 Unknown signed t à 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? page 2 s 1 ☐ Yas 2 DONO 1 ☐ Yas 2 ☐ No Division of Vital 25. Was casa referred to medical axaminer? Be 26. Place of Death (Check only ona) To. Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27 Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After t
completaly filled in by the funeri 5 Pending investigation or Attending 1 Matural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 4 Homicide the Hospital 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who completed cause of death (ftem 23a) (Type, Print) 711 MAIDEN CHOILE LANE CATONSVILLE, MD 21228 NALLETT

DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month, Day, Year)

JUL

32. Registrarie-Signatura

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month De 02:30 PM Smith Maryanne 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth Baltimore ST, Agnes 5. Social Security Number Mospital If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) 80 Yrs. Birthplece (State or Foreign Country) Days 1 □ M 2 19 F Yrs. 218 09 1354 11/04/1918 Md Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1₺ Yes 2 No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6202 Craigmont Road 21228 USA 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Detes: 1 Never Married 2 M Married 1 Yes ≥ No Specify: 3 ☐ Widowed 4 ☐ Divorced white 18a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Frank Poplawska Catherine Wegrcniak 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6202 Craigmont Road Catonsville, Md. 21228 John Smith/Son 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XDBuriel 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cem 08/10 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansia 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc 736 Edmondson Avenue, Balto, Md. 23a. Parti/Erfe) the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. 21228 Approximate Interval Between Onset and Death Immediate Cause (Finel Pulmonary Embolism disease or condition resulting in death) trial Fibrillat Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or as e consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Heart Failure 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Netural 2 Accident 5 Pending 1 Yes 2 No investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Division of Vital Records, P.O. Box 68760, Smith Mary

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Funeral

Director

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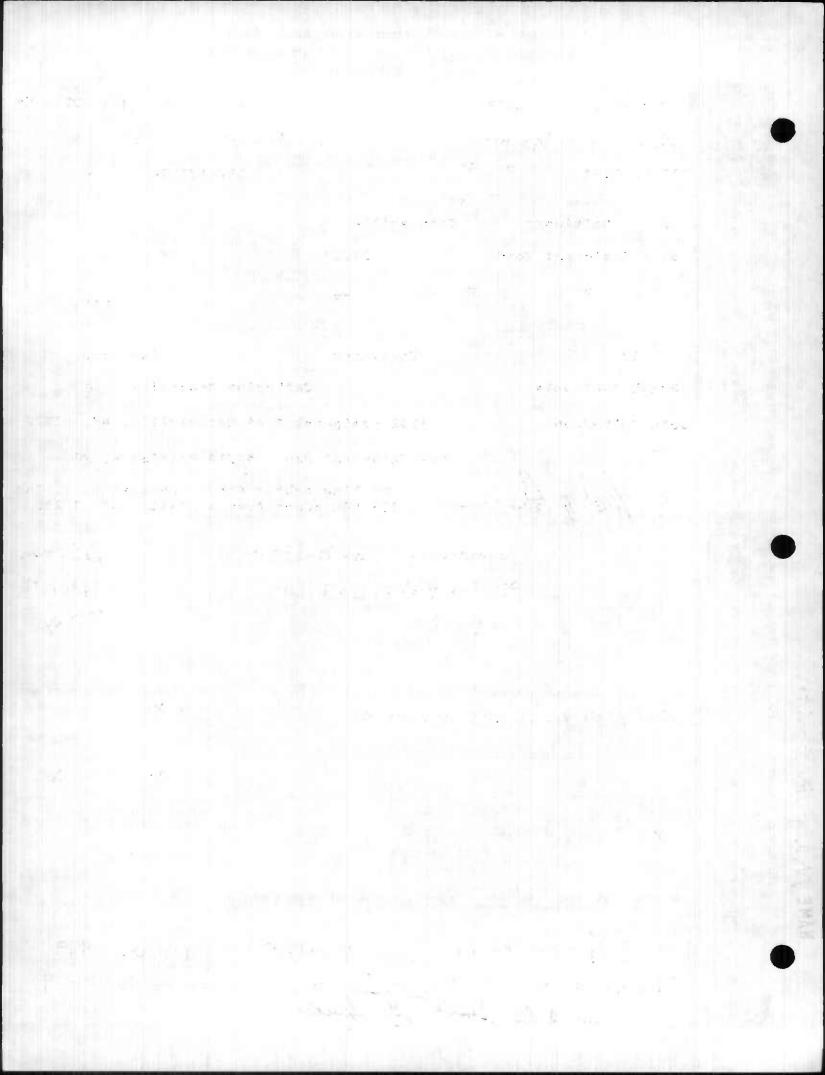
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30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

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Avenue, Baltimore, Maryland 21229 900 Ray 31. Date filed (Month, Dey,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time Deeth 2 Date of Death Month **Physician** JULY 4 1999 Evelyn Marie Serio 10:46 PM /Medicai 4b. City, Town, or Location of Death 4e Facility Neme (If not Institution, give street end number) 4c. County of Death **Examiner** Baltimore If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) St. Agnes Hospital 5. Sociel Security Number Birthplaca (Steta or Foreign Country) 7. Aga (In yrs. last birthday) **Funerai** Months Deys 1 □ M 2 □ NE 83 Yrs Director 220-24-4241 Usuel Residence of Decedent Nov 29,1915 Baltimore 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits to Yes 2 No Directo Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2653 Lehman Street 21223 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Nevar Married 2 Married 1 ☐ Yas 2 ☐XNo Specify: Specify: White b 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiemantary/Secondary (0-12) College (1-4or 5+) Homemaker 6th Grade Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) 2 Frederick Wright Daisy Sanders 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 914 Pine Heights Avenue - Baltimore, Maryland 21229 of Disposition (Name of Date 20c. Location - City or Town, State Joseph A. Serio (Son) 20b. Pleca of Disposition (Name of cametery, cremetory or other plece) 20a. Method of Disposition any injury or one 1 Buriei 2 Cremetion 3 Ramoval from Stata 4 □ Donetion 5 □ Other (Specify) Chapel Mausoleum Loudon Park Cemetery 7/8/99 Baltimore, Maryland 22. Name end Address of Fecility Hubbard Funeral Home, Inc. 21. Signatural Funarai Service Licensaa the the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, heart feiture. List only one ceuse on each line. **Approximate** Interval Batween Onset and Death **Physician** /Medical fmmediate Cause (Final disaese or condition resulting in death) 10(0/0 Examiner Due to (or es e consequence of) Examiner LOCU. 20 Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequenca of): Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably → Unknown by 24b. Were eutopsy findings available prior to 24e. Wes en autopsy performad? Completed 50 completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitei: 1 ☐ Yes 🗷 No Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of injury 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending Neturel 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end placa, end due to the cause(s) and menner es stated. Medical Examiner: On the besis of exemination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29e. Certifier edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

State

DHMH 16 Rev 6/95

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Department Important: If

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To the Hospital e within 24 hours e To the Funeral D

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Maryland 21215-0020

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7 is marked other than "natural", or itema 23a or 28a-f ahow trsumatic event, the Medical Examinat must be notified at

Registrar

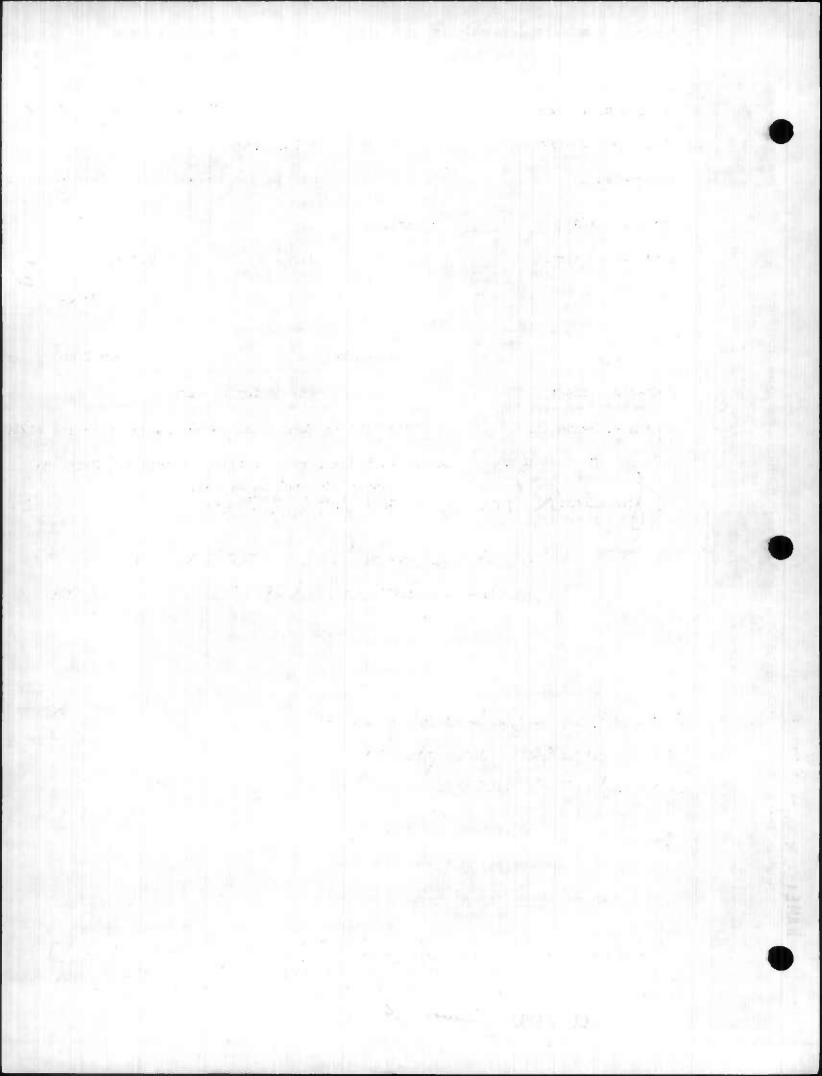
31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture 9 1999

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30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print)

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Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death AMENDED ITEM #28b PER M.E. G773 7/9/99 AH 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** JUNE /Medical 4b. City, Town, or Location of Deeth 4c. County of Death Fecility Neme (If not institution, give street end number) Examiner MARY LAND MEDICAL BALTIMORE of If Under 24 Hrs. 8. Dete of Birth (Month, Dey. If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 180 M 2 F Months Deys 214 94 8342 Feb. 23 6, Maryland Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or harmoniant or other treumstic event 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Catonsville 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 9 Howard Avenue 21228 U.S. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Meritel Status Biack, White, etc. 1 Never Merried 2 Married If Yes, Give Yeer or Detes: 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuei Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Delivery Man 12th Appliances 17 Fether's Neme (First Middle Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Linda Bielawski David Sevison 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent'a Neme/Relationship (Type, Print) Linda Sevison / Mother 9 Howard Avenue Catonsville, Maryland 21228 20b. Piece of Disposition (Name of cemetery, crematory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 N Buriet 2 ☐ Cremetion 3 ☐ Remove from State 6/29/99 Marriottsville, Md. Crestlawn Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Funeral Service/Libensee 22. Name end Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. mel plicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Intervei Between Onset end Death **Physician** · CLOSED HEAD INJURY SUBARACHNOID /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Examiner TEMORRHAGE physician and the burial-transit CERTIFICATION APPROVED BY MEDICAL EXAMINER The law requires that the death certificate be axecuted Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 981 ö 23b. Did tobacco usa contribute to the cause of deeth? ed by the a Pert It. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 200No 3 Probably 4 Unknown 1 Yee à 24b. Were autopsy findings eveilable prior to completion of cause of deeth? plnous 24a. Wes en eutopsy performed? Completed peeu has a 2 s certificate has 2 0 No 1 Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Wes case referred to medical examiner? Be 26. Plece of Death (Check only one) 1 X Yes Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P L 2 No this 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After Injury 1 Naturat 5 Pending CAR 2:15 1 Yes 2 No - (PEDESTRIAM JUNE 20 99 investigation STRUCK D 2 Accident 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 100,00

or Attending Physician: within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu Hospital

WESTDOUND Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as steted.

Medical Examiner: On the basis of examination and/or investination in my collabor deeth accurred at the time. 29a. Certifier Medical Examiner: On the basis of examinetion end/or investigetion, in my optnion, deeth occurred et the time, date and place, and due to the cause(s) end manner steted. title of certifier 29c. License number

29b. Sign

29d. Date signed (Month, Day, Year)

30. Neme and eddress of person who compi of death (item 23e) (Type, Print)

GREENE ST. BACTO, MID

State Registrar

Medical

31. Dete filed (Month, Dev. Year)

82. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies A

State of Maryland / Department of Health and Mental Hygi Certificate of Death

2. Date of Death Month

City

4b. City, Town, or Location of Deeth

Ellicott

21223

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.)

If Under 1 Year If Under 24 Hrs.

Baltimore

1 ☐ Yes 2 No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

10f. Zip Code

Are Legible.	
giene 99	21724
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ath Day Year	3. Time of Death
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4c. County of Dea	ath
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3/1313 110	itytana
	10d. Inside City Limits
	MYes 2□No
10g. Citizen of What C	ountry?
United S	States
- 14. Race - Am Bieck, Whi	
	hite
16b. Kind of Business	/Industry
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er, City or Town, State,	Zip Code)
x, MD 2113	81
20c. Location - City or	Town, Stete
Baltimore	, MD
P.A. Baltimore,	MD 21286
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rmed?	Were autopsy findings eveilable prior to completion of cause
	of death?

/Medicai Examiner **buriel-trensit** The law requires that the death certificate be executed physician s the buriel P.O. Box 68760 98 esn Records, Division of Vital Hospital or Attending Physician: director, this.

After

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within 24 hours efter deat To the Funeral Director:

To the

AMENDEDITEM #23a PER M.D. G773 7/9/99 AH

10a State

Maryland

10e. Street and Number

Physician

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Director

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items 23a

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pemit. Peges 1 and 2 should be filled within 72 hours effer or Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "naturel", or ite

Baltimore, Maryland 21215-0020

Director

Funeral

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1. Decedent's Neme (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

10b County

1057 Parksley Ave.

1 Never Married 2 Married

3 Widowed 4 Divorced

n/a

15. Decedent's Education (Specify only highest grade completed)

St. Agnes Nursing and Rehabilitation Ctr.

Sex 1□ M XXF

7. Age (In yrs. last birthday)

10c. City, Town or Location

89

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

32. Registrar's Signature

MARY

5. Social Security Number

215 18 9180

Usuel Residence of Decedent

treumetic event, the Medical Examiner must be notified at Completed Elementary/Secondary (0-12) College (1-4or 5+) Laborer 17. Father'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, M. George Morgan (Unknown) 19e. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Jacqueline McCormack / Daughter 14108 Fox Manor Lane, Pheonix 20a. Method of Disposition

1 Buriai 2 Cremation 3 Removal from State 20b. Placa of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 22. Name end Address of Facility
CAFA Stephen D. Lohrmann F 8717 Green Pastures Dr., B Entur the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory erre-or hour failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA Due to (or as a consequence of): Physician/Medical Examiner CEREBROVASCULAR ACCIDENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as e consequence of) Due to (or as a consequence of) DIABETES MELLITIS Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tob 1 Ye ģ Completed 24a. Was an lescaler Discess orones Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2010 Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Phyalcian: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) who completed cause of death (Item 23a) (Type, Print) se Rd Ellicatt City m/21043 31. Date filed (Month

State Registrar

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HARRIS STRUCKS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death JUL) Mary C. Soul 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deatl Church Home Hospital Baltimore N/A If Undar 24 Hrs. 5. Social Security Numbe 217-68-2120 7. Age (In yrs. last birthday) 86 Yrs. If Under 1 Yaar 8. Data of Birth (Month, Day, Year) 7-31-12 Birthplace (Stata or Foraign Country) Months Days 1□M 20XF MD Usual Rasidence of Decedent 10c. City, Town or Location 10d. fnsida Cltv Limits MD Baltimore Rosedale 1 Yas 2 No 10g. Citizen of What Country? USA 10e. Street and Number / 520 Philadelphia Rd. 10f. Zip Coda 21237 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Evar in U.S. Armed Forces? 14. Race - Amarican Indian, 11. Marital Status Black, White, atc. 1 Nevar Married 2 Married 1 ☐ Yas 2 🔯 No If Yes, Giva 1 ☐ Yas 2 No Specify: white Specify. 3 Widowed 4 Divorced Yaar or Datas: 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) SeamSLIESS 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Clothing 17. Father'a Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Michael Soul Anna Fisher 19a. Informant'a Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Suzanne Soul / niece 44 Theo Lane, Towson, MD 21204 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Removal from Stata 4 Donation 5 Othar (Specify) 7-8-99 Most Holy Redeemer Baltimore, MD 22. Nama and Addrass of Facility Cvach/Rosedale Funeral Home 21. Signatura of Funaral Sarvice Lice 1211 Chesaco Ave. Rosedale. MD 23a. Part1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onsat and Daath Immediata Causa (Finel disaasa or condition rasulting In death) SIGMOID INFECTION Weeker lan BOWEL Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco usa contribute to the cause of death? 1 Yaa 20 No 3 Probably 4 Unknown NEUMONIA 24b. Wara autopsy findings available prior to complation of causa of daath? 24a. Was an autopsy performed? 1 Yas 20 No 2 12 No 1 Yas 25. Was casa referred to medical axaminar? 26. Place of Deeth (Check only one) 1 Yas 2 No Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Dinpatient 2 ER/Outpatient 3 DOA 26a. Date of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending invastigation 1 | Yas 2 | No

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Examiner

Physician/Medical

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2 Accident

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(Check only one)

29b. Signatura and titla of certifier

Physician

/Medical

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Directo

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Funeral

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If item 27 is marked other than "natural", or items 23s or 28s-f shot or other traumstic event, my Medical Examinar must be notified at

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Division of Vital Records, P.O. Box 68760, signed by t certificate has al or Attending P s after death. I Director: After Hospital 24 hours a Funeral D

To the I within 2

State Registrar

8 Could not be datarmined

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28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29c. Licensa number

Cortifying Physician: To the best of my knowledge, death occurred at the time, dele end plece, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

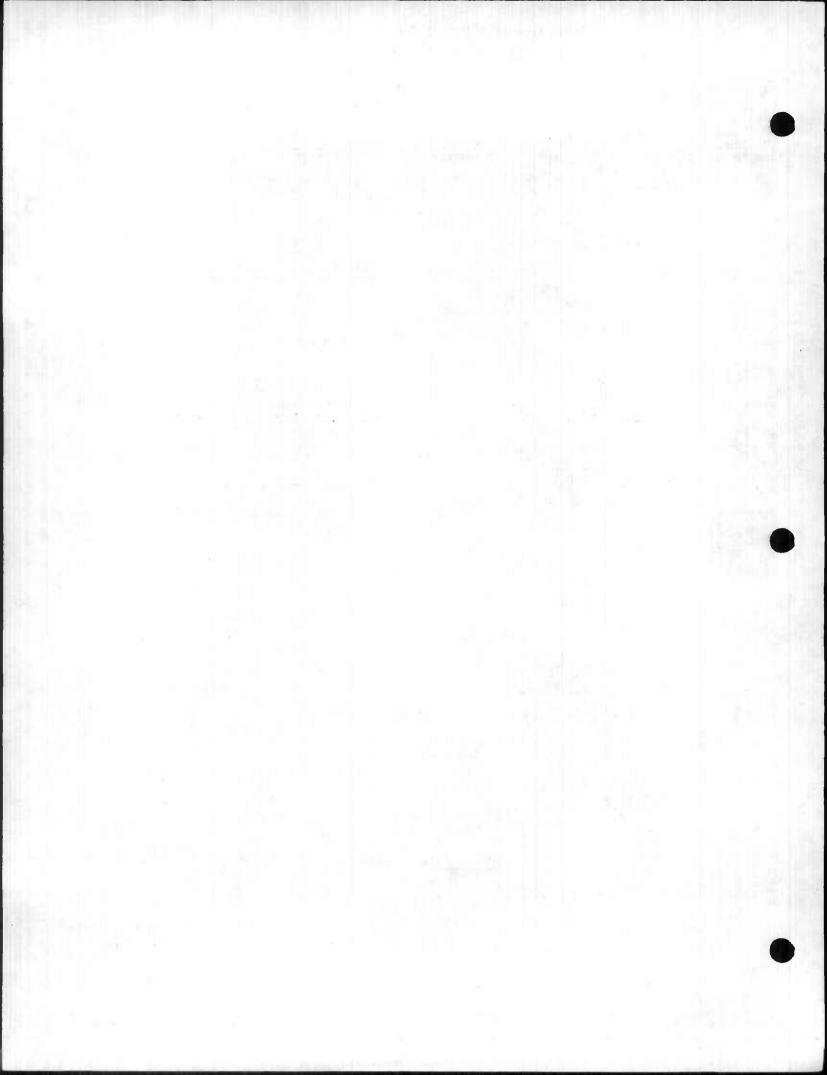
28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

Baltimon Maryland 2/23/

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 N. Broadway 20 Mg. 100 32. Registrar's Signatura NENGLISA NAVARRO

31. Data filed (Month, Dey, Year) JUL 09 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Yeer Month 6:46 P.M. 24 1999 Cedric R. Taylor June 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Deeth BAITIMORE Nosedale If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Dey, Year) FRANKlin Square Hospital Cen 5. Sociel Security Number (6. Sex A. Age (In yrs. lest birthday) CenTer If Under 1 Year Birthplece (State or Foreign Country) Months 10XM 20 F 91 Aug. 29,1907 190-14-0648 Usual Residence of Decedent 10c. City. Town or Location 10d, Inside City Limits 10e. State 10b. County 1 ☐ Yes 2 No Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 1711 Hilltop Avenue 21221 14. Raca - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 21 No Specify: 3X Widowed 4 □ Divorced Yeer or Detes: 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 Welder Crown, Cork & Seal Co. 18. Mother's Nama (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) John Leroy Taylor Hattie Angelia Wescott 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Margaret Edelmann/daughter 1711 Hilltop AVe., Baltimore, MD 21221 20b. Placa of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 X Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Servica Licansee 22. Name end Address of Fecility Ronald S. Wade, Director State Anatomy Board, 655 W. Baltimore, MD 21201 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, nock, or heart feiture. List only one cause on each line. State Anatomy Board, 655 W. Baltimore St. Approximata tnterval Between Onset end Deeth Immediata Causa (Final e. Congestive Heart Due to (or es a consequence of): disease or condition resulting in deeth) / MONTH CORONARY ARTERY Due to for es a consequence of): Sequentielly list conditions, it eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown Chronic ObsTructive Pulmonary Disease 24b. Were autopsy findings evaltable prior to completion of cause of daath? 24a. Was an autopsy performed? Myo CARdial InFARCTION BRAIN TUMOR, ADRTIC STENOSIS 25. Wes case raferred to medical exeminer? 1 ☐ Yes 2 ☐ No 26. Placa of Deeth (Check only ona) Hospitel: 1 Inpatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Neturel 5 Pending Investigation 1 Yes 2 No 2 Accident

attending physician and for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician: After this of funeral dir ne Hospital or Attending Pin 24 hours after death.

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Physician

/Medical

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Department of Health Important: If Item 27

Physician /Medical

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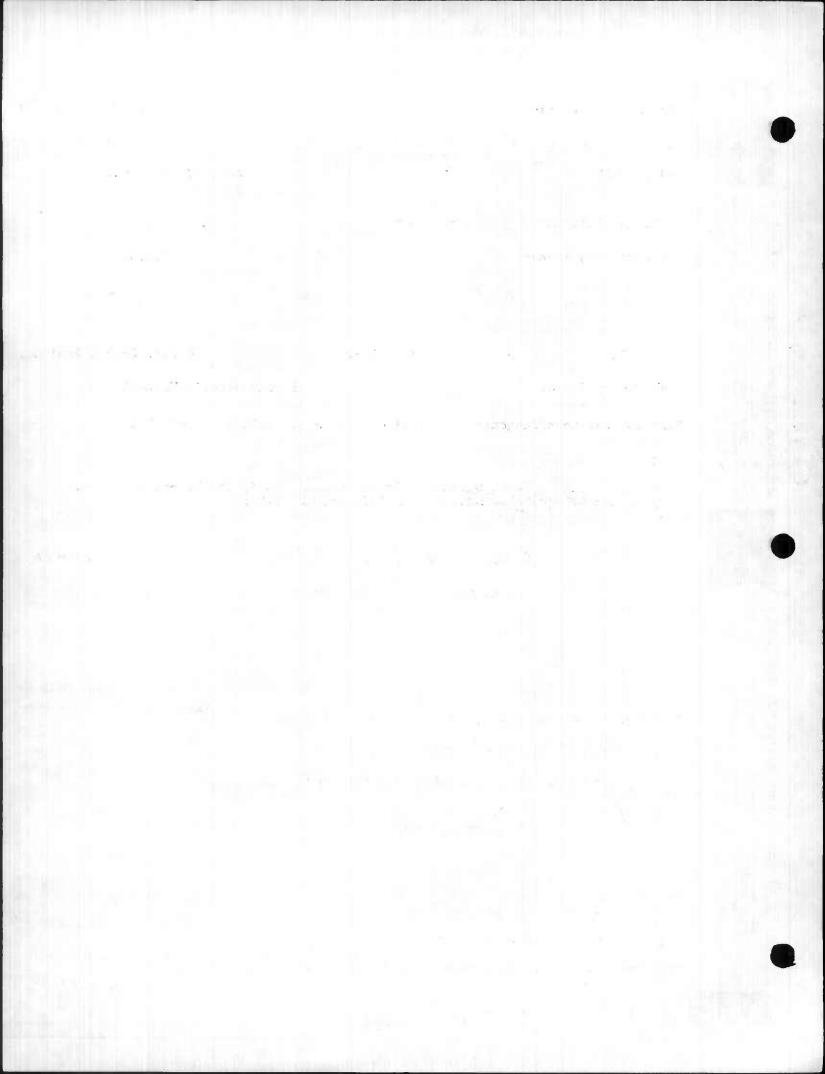
1 Certifying Physician: To the best of my knowledga, daath occurred et the time, data and place, and dua to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred at the time, date end place, and dua to the cause(s) and menner steted. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of kertifier

D53925 30. Nama and addrass of person who completed cause of deeth (Itam 23a) (Type, Print) 9000 FRANKLIN SELLANE
SEAN BENERIHOUTE M? BAITIMORE. MANUELANE DR. BAITIMORE, MARY LAND 21237 31. Date filed (Month, Day, Year)

State Registrar

0 9 1999

32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) Martha Elizabeth Tillman 4c. County of Death 4b. City, Town, or Location of De 4a Facility Neme (If not institution, give street and number) Levindale Hebrew Geriatric Center & Hospital Baltimore N/A7. Age (In yrs. last birthday) If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex Days 1 M 2 XF Months Hours Min. Yrs. 219-40-1805 54 MAR 9, 1945 South Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2434 W. Belvedere Avenue 21215 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 🎾 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Clothing Elementary/Secondary (0-12) College (1-4or 5+) 10 Distributing Laborer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Robert Tillman Lonnie Grey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 710 Pennsylvania Ave. Andrew Lee Tillman/son Baltimore, MD 21201 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 7/8/99 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Funeral Service License Dawn F. McDonald 299 Frederick Road Bal 239. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, MD 21228 Approximate interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Thumbosis (orebra) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably \$ \$ Unknown 24b. Were autopsy tindings evailable prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ do 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death 28b. Time of 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide

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Physician

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Director

Examiner number

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Director ŏ 24 hours To the Hosp within 24 hou To the Fune completely fi

> State Registrar

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cauaa(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D47683 6/99 Mili 30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print) 25- - Man Street Sinte

Rayned Miller 31. Date tiled (Month, Day, Year) 9 1999 32. Registrar's Signature

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Physician UNDERWOOD JULY 99 DONNELL 2211 6 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY 7. Age (In yrs. last birthday) If Under 1 Year Months Days OFMARK BALTIMORE If Under 24 Hrs. 5. Sociel Security Number 6. Sex Birthplace (State or Foreign Country) Days 220-84-928 1XM 2□ F Hours MAR Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MARVLAND 10e. Street and Number 10g, Citizen of What Country? USA, 14. Race - American Indian, Black, White, etc. 3222 05 STREE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Deles: 11. Merital Status 1 Never Merried 200 Merried 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced ACI Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 + HGRADE 4 S INCORPORATED JANITORIAL SUPERVISOR 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SIMMONS MCCLEAN UNDERWOOD UNDERWOOD DOROTHV B. 19b. Mailing Address (Street and Number or Rural Route/Number, City or Town, State, Zip Code) 19a. Informant's Name/Raietionship (Type, Print) 3232 LEEOS STREET, BALTIHORE, MO. 21229 ce of Disposition (Name of Date 20c. Location - City or Town, State DENISE H. UNDERWOOD (WIFE) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 1 Buriai 2 □ Cremetion 3 □ Removel from State KING MEMORIAL PARK 22. Name and Address of Facility 07-12-99 WOODLAWN, MARYLAND 4 Donetion 5 ☐ Other (Specify) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Approximate 21. Signature Fuherei Service Litensee Approximate Interval Between Onset and Death SEPTICEMIA immediata Causa (Final diseese or condition rasulting in deeth) Due to (or as a consequence of) Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): AIDS Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case raferrad to medical examinar? 26. Place of Death (Check only one) 8 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? Certification: 5 Pending investigation Natural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Box 68760 the death certificate be P.O. Division of Vital Records, To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely tilled in by the funera

Funeral

Director

28a-f show must be notified at

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Herns 23a

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Department of Health and Mental Hygiene important: if flem 27 is marked other than 'n any Injury or other traumate.

Physician /Medical

Examiner

physician and the burial-transit

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certificate

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29a. Certifier

(Check only one)

29b. Signature and titlé of certifier

31. Date filed (Month, Dey, Year)

DEBRA

JUL 0 9 1999

Medical

72 hours after

Baltimore, Maryland 21215-0020

State Registrar DHMH 16 Rev 6/95

ORIGINAL

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29d. Date signed (Month, Day, Year)

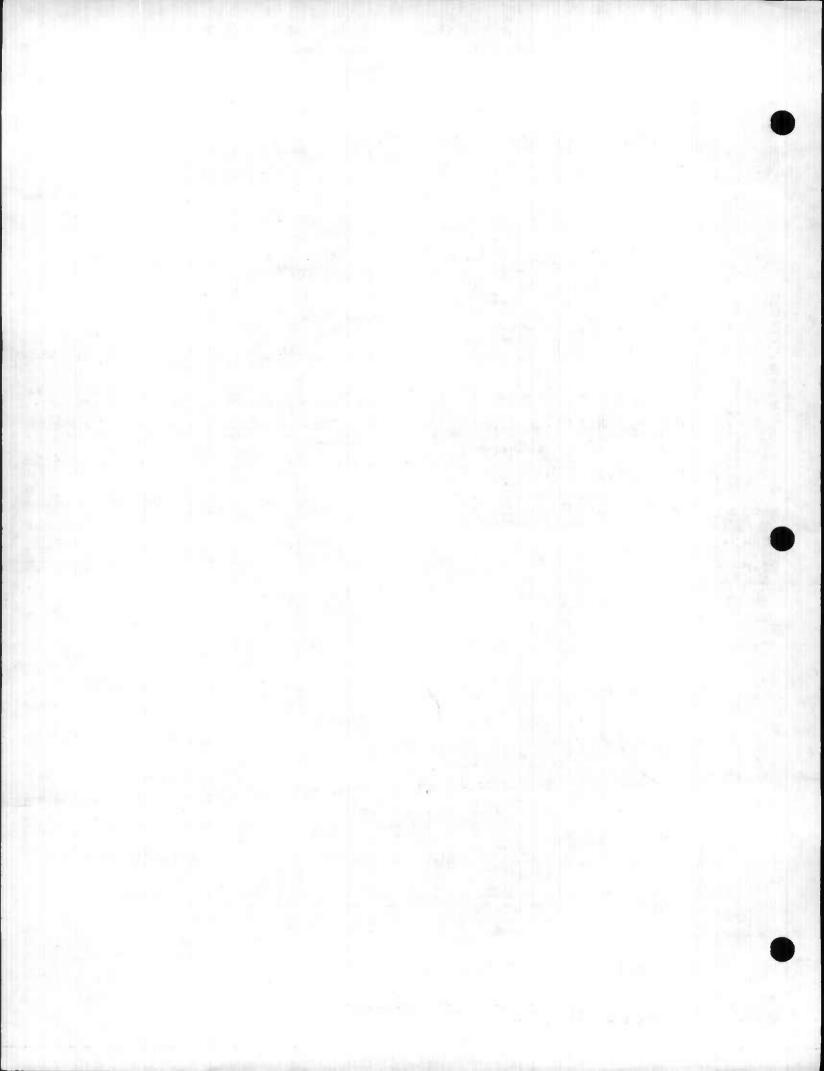
29c. License number

711735

30. Neme and addrass of person who completed cause of deeth (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

M.D. 22 South GREENS ST



99-2855-510 UNK 99-107 asp

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / D

epartment	or Health and	Mentai	Hygiene
Certificate	of Death		Rea No."

Physician	
/Medical	
Examiner	

Funeral

Director the Manyland mast be notified at death with Herra 2 "natural", or item idical Examiner. filed within 72 hours after the Medical Hygiena.

21215-0020

Baltimore, Maryland

Peges 1 and 2 should be 1 nent of Health and Mental or other train Department of important: if any injury or Physician /Medical

Examiner Examiner tha bunal-transit or Attending Physician: The law requires that the deeth certificate be executed Box 68760. Physician/Medical for usa as signed by the a d be detached f P.O. Division of Vital Records, Completed by should page 2 s has certificate director, Be Medicai Certification: To this funeral Aftar deeth. within 24 hours after deet To the Funeral Director: filled in by

1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Unk. 99-107 MAY 18 1999 4:10 A 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 1027 W. LANVALE ST. BALTIMORE If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Months Deys 15 M 2□ F unknown unknown unknown unknown Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits unknown unknown unknown unknown 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral unknown unknown unknown
14. Race - American Indien, 11. Meritel Status unknown 12. Wes Decedent Ever in U.S. Armed Forces?unknown 1 Yes 2 No Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Merried 2 ☐ Married If Yes, Give Yeer or Detes: 1 Yes 2 No Specify: Specify: black þ 3 ☐ Widowed 4 ☐ Divorced unknown Completed Seedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown unknown 19e. Informent's Neme/Relationship (Type, Pnint) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown unknown 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4□Donetion 5☑Other (Specify)in state wade Director 21. Signature of Runeral Service Licensee 22. Name end Address of Fecility Ronald. State Anatomy Board, 655 W. Baltimore Street Fert1. Enter the discesse, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediete Ceuse (Final disease or condition resulting in death) sease Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or as e consequenca of) Due to (or as e consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause 1 Yes 2 No 2 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Dother (Specify) SCENE XXYes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1. Netural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Certifier (Check only one)

State Registrar

complately

29b. Signature and title of cartifier

RL 30. Name and appress of person who completed cause of death (Item 23a) (Type, Print)

28

32. Registrer's Signeture

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0 Dey, Year)

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JUL

Hospital

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29c. License number

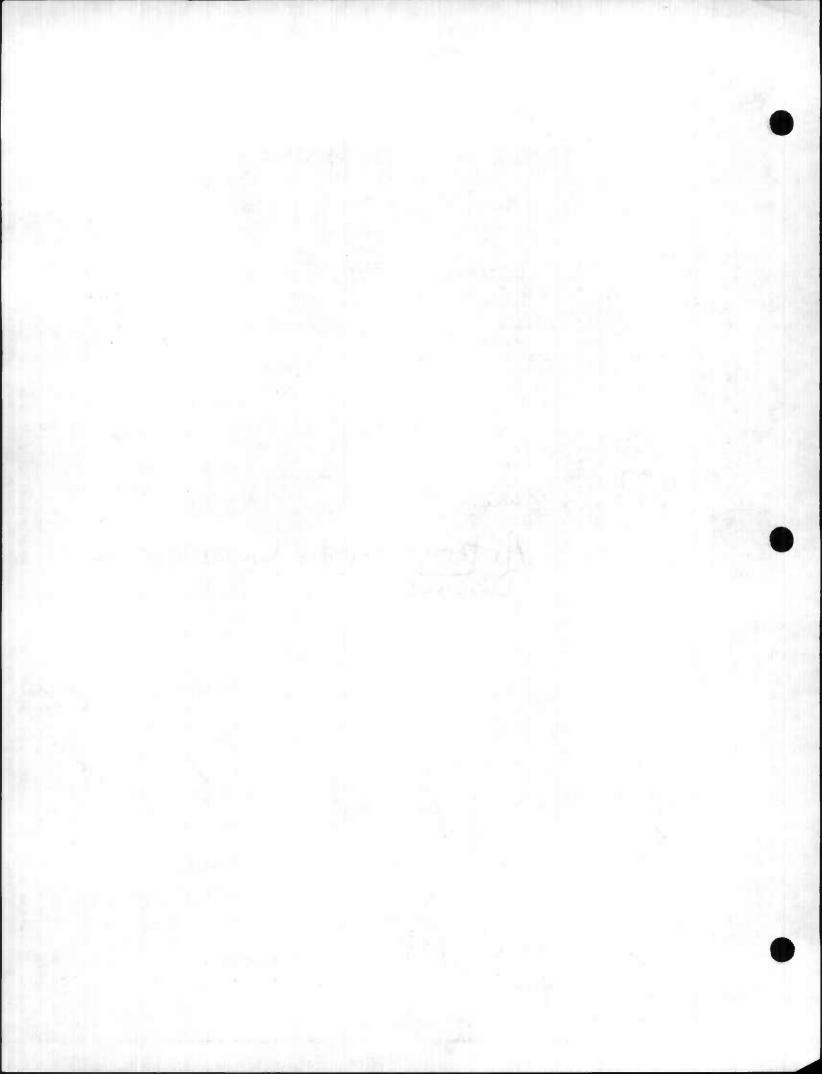
O.C.M.E

29d. Date signed (Month, Day, Year)

18,1999

MAY

turchil Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Registrar

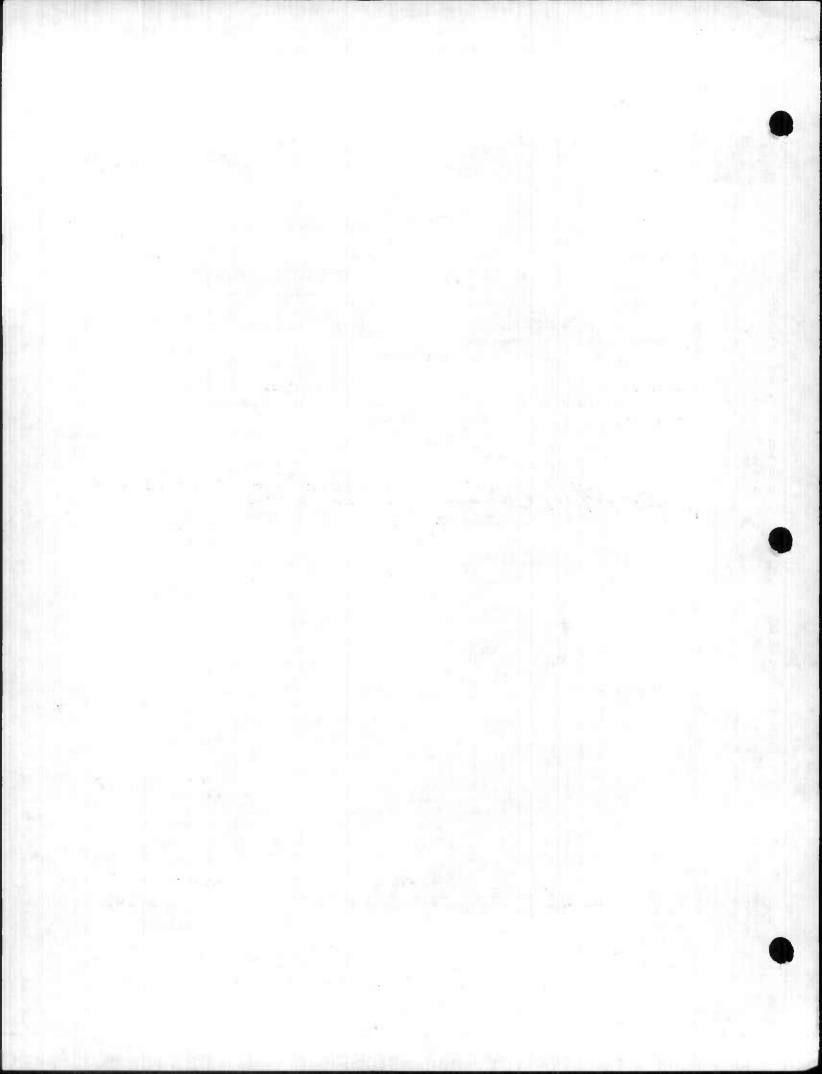
State

31. Date filed (Month, Day, Year)

ORIGINAL

Sports

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Dep

partment of Health and N	Mental Hygiene	00	0	9	any A	
partment of Health and Nertificate of Death	Reg. No.	75	6	1	13	
	2 Date of Death			2 .	Time of	D.

Fun Direc

permit. Peges 1 and 2 should be filled within 72 hours efter death with the Maryland Department of Health end Mental thygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f ehow Baltimore, Maryland 21215-0020

Physic /Med Exami

To the Hospital or Attending Physician: The law requires that the death certificate be assect within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician enc competaty filled in by the funeral director, paga 2 should be datached for use as the bunal-ira

Division of Vital Records, P.O. Box 68760,

Decedent's Nama (First, Middle, La	ast)							2. Data of Da Month	Day	Yaar	3. Time of Death
Unknown 99-044								March		99	7:31 A.M.
4a Facility Nama (If not institution, given	va straat end number)				- 1	4b. City, Tov	wn, or Lo	ocation of Deat	h 4c. Cour	ity of Death	
3800 Block of Bu	ena Vista	Avenue				Bal	time	ore	1	J/A	
5. Social Security Number 6.	Sex 7. Age	e (In yrs. lest	birthday)	If Under 1 Months	Yaar	If Under a	24 Hrs. Min.	8. Date of Bir (Month, De	rth	9. Birthp	olaca (Steta or Foreign
unknown	own 1≅M 2□F unknown				Days	110013		unknow		unkne	
Usual Residence of Decedent											
10a. State 10b. County		10c. City, To	own or Loca	ation						1	IOd. Inside City Limits
unknown unknown		unkno	own							uı	nknown
10a. Street and Number				10f. Zip 0	Code		- 1		10g. Citizen o		
unknown									1		
11. Marital Status unknown	12. Was Decedent 8	Ever In U.S.	13. W	unkn as Decede			oin? (Sp	ecify Yes or No Rican, etc.)	unknown	ace - Amaric	can Indian,
1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ N	unknov	vn If	Yes, specif	y Cuba	an, Mexican	, Puarto	Rican, etc.)	В	lack, White,	atc.
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:				□ No	Specify:			Spec	white	te
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17. Father's Name (First, Middle, Last	t)							e (First, Middle	, Meiden Sum	erne)	
unknown						unkn	own				
19a. Informant's Name/Relationship	(Type, Print)	1	9b. Mailing	Address (Street	end Numbe	r or Aur	el Route Numb	er, City or Tow	m, Stete, Zip	Code)
unknown		_ 1	ınknov	vn							
20a. Method of Disposition		20b. Place	of Disposi	tion (Nem	e of	ce)		Dete	20c. Location	n - City or To	own, Slate
1 Burial 2 Cramation 3		Cerrie	nery, creme	story or our	rer pre	06)	į				
21 Signature of Furnaral Service Lice Ronald S 23a Hartt. Enter the disease, or connock, or heart failure. List only	S. Wade, Di	the death. D	Sta	ate A Ltimo	nat re,	MD :	oard 2120	1	W. Balt	imore	Street Approximete Interval Between Onsal and Daath
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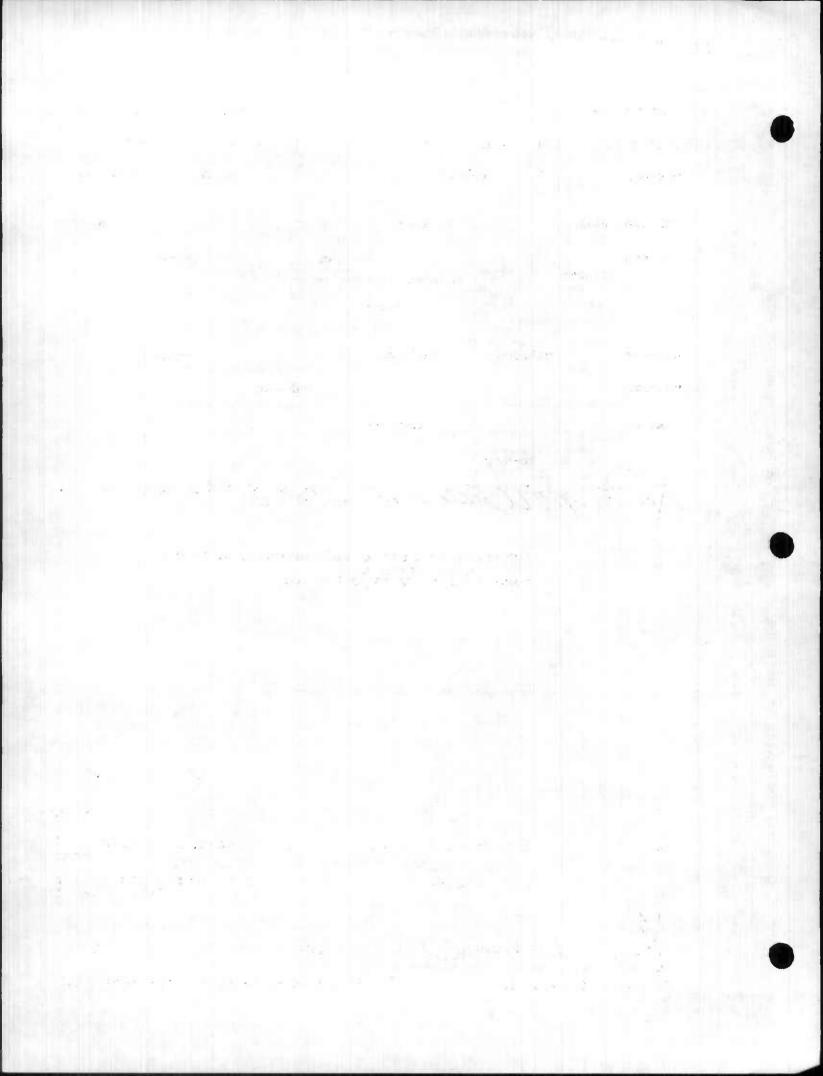
March 01, 1999

State Registrar

31. Dete filed (Month, Dey, Yeer)
JUL 0 9 1999

111 Penn Street, Baltimore, Maryland 21201 J. Laron Locke, M.D. 32. Registrar's Signeture porks

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

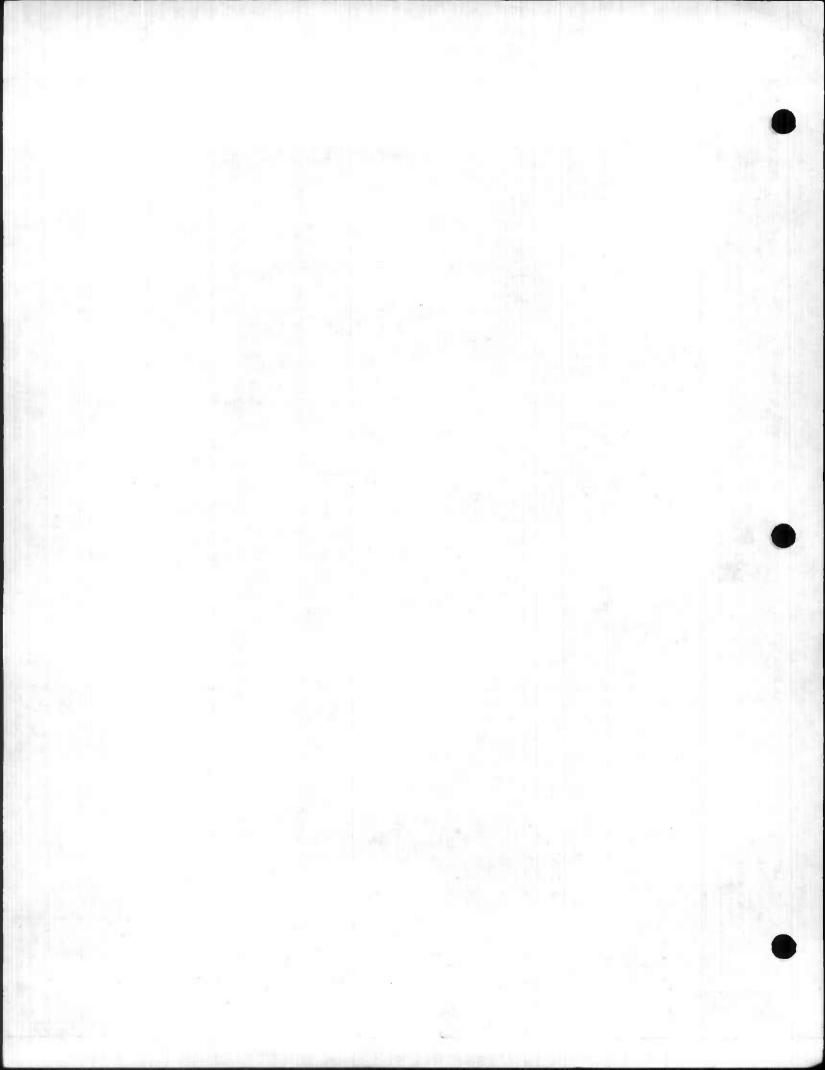


99-2600-510 jhm UNK. 99-091

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

cian	1. Decedent's Name (First, Middl	e, Last)		Cei	incate c	of Death	2. Dete of D	Reg. No.	3. T	ime of Death	-
	Ernest Walte	r					Month	Day	Year		
lical iner	4a Facility Name (If not institution		ber)			4b. City, Town, or	MAY 0 Location of Dear	6, 1999 th 4c. County		3:40 PM	
	JOHN HOPKINS	RAVVIEW HOS	SDTTAL			BALTIMOR	RE.				
ı	5. Social Security Number		Age (In yrs.	last birthday)	If Under 1 Ye Months Da	er If Under 24 Hr	8. Dete of Bi	rth ey, Year)	9. Birthplace (3 Country)	Stete or Foreign	
r	unknown Usual Residence of Decedent	ICXM 2UF	60	Yrs.			May 3,	1936	ınknown		
	10a. Stele 10b. County		10c. C	ty, Town or Lo	cation				10d. Ins	side City Limits	
jo	Maryland		Po1	timore						Yes 2 No	
Director	10e. Street and Number		рал	LIMOTE	10f. Zip Cod	0		10g. Citizen of V	What Country?		
	114 South Broad	wav			2123	1		unknown			
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	1 Never Married 2 Men	ied 1 Yes 2	□ No		Tes, specify C		rio riioari, etc.,		white		
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	unknown 17. Father's Neme (First, Middle,	unknown Last)		unknov	wn	18. Mother's Ne	eme (First, Middle	unknowr , Maiden Sumen			
o Be	unknown					unknown					
Ĕ	19e. Informent's Neme/Reletions	hip (Type, Print)		19b. Mailir	ng Address (Str	set end Number or F	Rural Route Numi	ber. City or Town.	Stete. Zip Code)	
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	20a. Method of Disposition		20b.	Place of Dispo	sition (Neme of	-4	Dete	20c. Location -	City or Town, St	ele	
	1 ☐ Burial 2 ☐ Cremetion 4 ☐ Donation 5 ☑ Other (S	3 □Removel from St	ele	cemetery, cren	netory or other (Diace)					
	21. Signature of Futural Service			22	. Name and Ad	dress of Fecility					
	Ronald	S, Wade, D	irecto			atomy Boar		W. Balti	more St	reet	
	23a Part 1 Foter the disease or	complications that cau	sad the dea		altimor		201	arraet	Appr	oximete	
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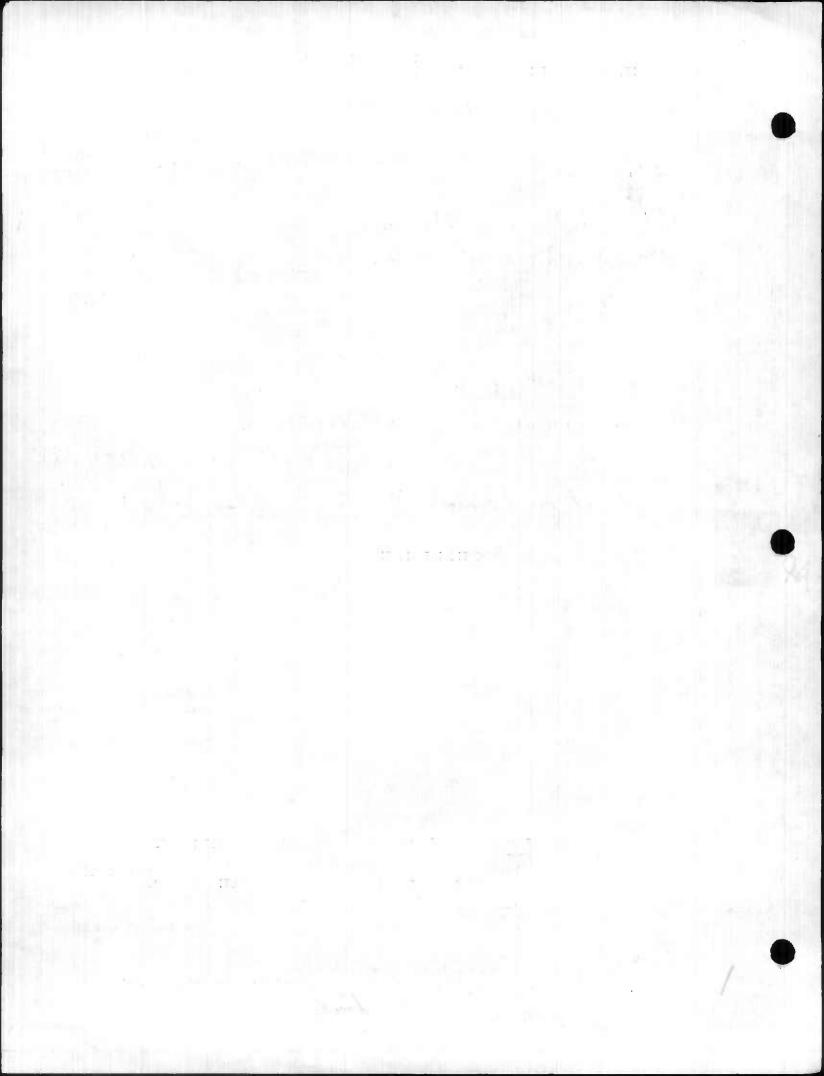


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	/Medica	er	4a Facility Neme (If not institution, give 313 EDGEDALE ROA 5. Social, Security Number 4. 6. Se	AD APT.E	thday) If Under 1 Yee	4b. City, Town, or L BALTIMOF	ocation of Death	4c. County	of Death	
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20	6 6	a	3/3 E QG (QQ 11. Merital Status 1 Never Married 2 Merried	12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes 20 No It Yes, Give	13. Was Decedent of If Yes, specify Cu	ban, Mexican, Puerti	pecify Yes or No Pican, etc.)		e - Americar k, White, et	
21215-0020	within 72 hours lene. • than "natural", the Weddell Ex	Completed b	15. Decedent'a Edi (Specify only highest grad		Decedent's Usual Occi (Give kind of work don- life. DO NOT use retir	e during most of world	king	16b. Kind of Bu	isiness/Indu	stry
Maryland	Mental H Mental H arked oth	To Be C	17. Father's Name (First, Middle, Last)	ehead Sr.	Mailine Address /Circ	18. Mother's Nam APSTIY	ne Ch	amber	S	Parda 1
	of Health ard filtern 27 la		19a, Informent's Name/Reletionship (7. OPES A TIME 20e. Method of Disposition 1 128 Buriat 2 Cremation 3 1	10 re - Sister 2	Mailing Address (Street) Diaposition (Name of y, cremetory or other pl	ner Circ	Pate Date	20c. Location	31	1225
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68760,	e be	dical Examiner	Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): C. Due to (or es a consequence of):						
Box 6	death certificate be attending physical for use as the b	2		d						
P.0.	d by the letached	F	Part II. Other algnificant conditions co	ntributing to death but not resulting Ir	n the underlying cause g	iven in Part I.		obacco use col	ntribute to t	the cause of death?
Records,	8 50 .	Completed by					perlo	en eutopsy med? rcfien	avail	e autopsy findings lable prior to pletion of cause eath?
alF	certificate harector, page		OF Management					res 2 No	10	Yes 2□ No
Vital	99 155	0	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	tpatient 3 DOA	26. Place of Dea	ome XX Resi		er (Snacity)	
Division of	5 5 8	Certification: 1	27. Manner of Death 1	28a. Date of Injury (Manth, Day Year) Found: 7-5-99 28b. T Four 3:4	Time of A 28c. Inj	ury at ork? ☐ Yes 2 ☐ No	SUBJECT	NGESTED	RUGS	
DİV	tal or At ins after al Direction by		4 Homicide determined	28e. Plece of Injury - At home, fa building, etc. (Specify) FOUND AT		•	City or To	Street and Numb vn. State) 313 E, MARYLAN	EDGEDA	LE ROAD
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only XX Medical Exami	sician: To the best of my knowledge ner: On the basis of examination and and manner stated.	d/or investigation, in my	opinion, death occu	, and due to the rred at the time,	date and place,	and due to t	the cause(s)
	To the within To the comple		29b. Signature and title of certifier 30. Name and address of person who ce	Made	MD 0	.C.M.E		29d. Date aigne JULY 5		
	State		- 1 · · · · · · · · · · · · · · · · · ·		Penn Street	, Baltimon	re, Mary	land 21	201	

Registrar
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1999 0915 AM **Physician** 7, DENNIS WHITTEN JULY /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 606 BAKER STREET BALTIMORE N/A If Under 1 Yeer | If Under 24 Hrs. 6. Sex 10 M 20 F Date of Birth (Month, Day, Year) 2-18-24 Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours Yrs. 239-26-6128 75 N.C. Director Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√2 Yes 2 No Director 25a-f MD N/A BALTIMORE 8 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 21217 238 606 BAKER ST. USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11 Meritel Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK à 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Hygiene. other than Elementery/Secondary (0-12) College (1-4or 5+) -10-COOK RAILROAD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental UNKNOWN UNKNOWN 19a, Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a If Item 27 is or other tre ERNESTINE BYRD-WHITTEN(WIFE) 606 BAKER ST. BALTIMORE, MARYLAND 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date t Burial 2 ☐ Cremation 3 ☐ Removal from State MT. ZION CEMETERY 7-12-99 BALTIMORE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signeture of Funeral Service License 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** tmmediete Cause (Finel diseese or condition resulting in death) /Medical Hypertensive Arteriosclerotic Cardiovascular Disease Examiner Due to (or as e consequence of): The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as e consequence of) US9 85 signed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 3 Probably 4 Hnknown 1 Yes 2 No ENVIRONMENTAL HYPERTHERMIA Records, Be Completed by 24b. Were autopsy findings available prior to page 2 should 24a. Was an autopsy peed completion of cause of death? INSPECTION certificate 1 Yes 30 No 1 Yes 2 No Division of Vitai or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 1 No 2 No Certification: To ome 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After SUBJECT EXPOSED TO HIGH ENVIRONMENTAL TEMPERATURE 1 Naturel 5 Pending FOUND₇₋₇₋₉₉ UNK 1 ☐ Yes 2 💢 💢 🖰 24 hours after death.

Funeral Director: A investigation XX Accident 3 ☐ Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 606 Baker Street 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) in by 4 Homicide RESIDENCE filled Hospital Baltimore, Maryland Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. completely (Check only one) Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner steled. within 2 To the \$ 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 0 O.C.M.E. JULY 8, 1999 30. Nama and address of person who completed cause of deeth (Item 23s) (Type, Print) Stephen Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signetura State Registrar

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street to the street of

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 5 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedant's Name (First, Middle, Last) 1930 JUNE 1999 ALBERT HENRY WADE 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Deeth HEIGHTS PRINCE GEORGES HALLECK STREET USTRICT If Undar 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Sacurity Number Birthplace (Stata or Foreign Country) 7. Age (In yrs. last birthday) Months TEM 20 F Yrs. 231-05-5062 81 AUG. 1917 VIRGINIA Usual Rasidance of Decedant 10a State 10d. Inside City Limits 10h County 10c. City. Town or Location Yas 2 No MD. DISTRICT HEIGHTS PRINCE GEORGES 10f. Zip Coda 10e. Street and Number 10g. Citizen of What Country? 7129 HALLECK STREET 20747-2323 USA 12. Was Decedant Evar in U,S. Armed Forcas? 1 M Yes 2 □ No If Yas, Giva Year or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. 1 Never Marriad 2 Married Specify: WHITE 1 Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15 Decedent's Education 16b. Kind of Businass/Industry (Specify only highest grada completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) 12 OWNER- SHOE STORE RETAIL SALES 17. Fether's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Surneme) JOHN HENRY WADE CORA KIDD 19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, Stata, Zip Coda) 7129 HALLECK ST. DISTRICT HEIGHTS, MD 19a, informant's Name/Ralationship (Type, Print) CORA KIDD WADE 20747 20a. Mathod of Disposition 20b. Place of Disposition (Nema of 20c. Location - City or Town, Stata MT. HERMON CHURCH 1 X Burial 2 □ Cramation 3 □ Ramoval from Stata BASSET, VA. 4 ☐ Donation 5 ☐ Othar (Specify) BRETHERN CEMETERY 6/23/99 22. Name and Address of Facility 5130 WISCONSIN AVE 21. Signature of Funaral Sarvice Licensee WASHINGTON, DC. homas 20016 -lon 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart fellure. List only one ceuse on each line. Approximata Intarval Batwaan Onset and Death Immedieta Causa (Final ARTERIOSCUEROTIC CARDIOVASCULAR DISEASE disaasa or conditior resulting in daath) Dua to (or as a consequence of) Sequentielly list conditions, if any, laeding to immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury that initiated events resulting in daeth) Last Due to (or as a consequence of): Dua to (or as a consequence of) 23b. Did tobacco use contribute to the ceuse of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy complation of ceusa of death? 1 Yes 2 WNo 1 Yas 2 No 26. Pleca of Daath (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 ☐ Yas 2 ☐ No invastigation 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

certificate be executed buriel-tren pue P.O. Box 68760. the 98 attending esn 20 the signed by the Records. peen page 2 hes certificate Division of Vital Hospital or Attending Physician: director. this funeral After efter death.

Physician

/Medical

Examiner

Funeral

Director

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7 is marked other than "natural", or items traumatic event, the Medical Examiner man

Hygiene.

Pages 1 end 2 should be filt ment of Health and Mentel Hyant: If Item 27 is marked oth jury or other traumstic event

Department or Important: If any injury or once.

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was cese referred to medical exeminer? 1 Yas 2 No 27. Manger of Deeth 1 Natural 2 Accidant 3 Suicide 6 Could not be datarmined 28a. Place of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 4 Homicide

29a. Cartifian

1 Certifying Physician: To the best of my knowledge, death occurred at the time, deta and place, and due to the cause(s) and mennar as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signature

IIIII

29d. Date signed (Month, Day, Year) 29c. License number

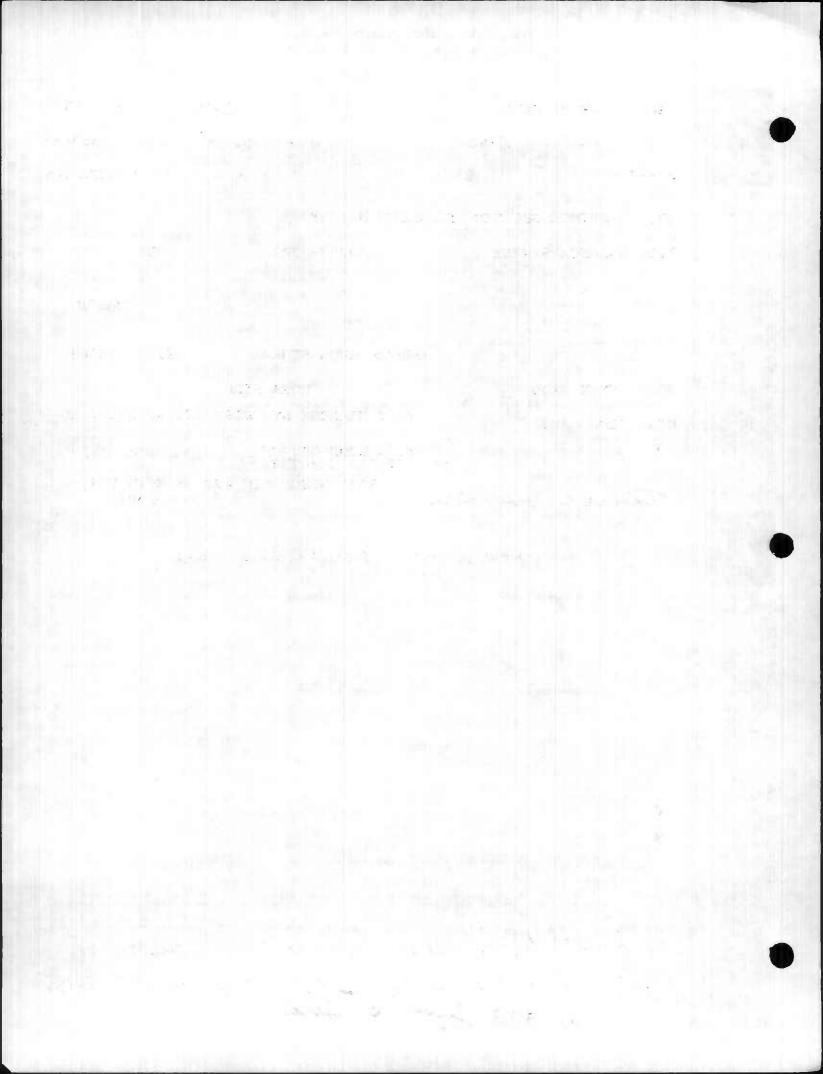
30. Name and eddress of parson who compla ause of death (Item 23a) (Type, Print)

HOSPITAL CHEVELLY MARYLAND MO MANO T- GOLLE 3001 31. Data filed (Month, Day, Year) 32. Registrer 3 Signatura

State Registrar

24 hours

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Paul Crosby Waldman July 1999 0640 1 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death St. Agnes HealthCare - 900 Caton Avenue Baltimore Baltimore City If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpiace (State or Foreign Country) Days Months 1⊠M 2□ F Hours 215-07-2603 86 Sep. 12, 1914 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Maryland Baltimore Catonsville 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 719 Maiden Choice Lane, HR 606 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Biack, White, etc. 1 XYes 2 No 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) 12 Administrative Manager Oil Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Waldman Mary Parrish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 2 28 Catherine D. Waldman / Wife 719 Maiden Choice Lane, HR 606, Catonsville, Md 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burlai 2 □ Cremation 3 □ Removal from State 5 Other (Specify) Dulaney Valley Mem. Gar. 7/3/99 Timonium, Maryland of Figeral Service Co 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Renal failure days disease or condition resulting in death) Due to (or as a consequenca of): Obstructive jaundice days-weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Carcinoma of biliary tree months that Initiated events resulting in death) Last Due to (or as a consequenca of) Part II. Other elanificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown Atrial fibrillation 24b. Were autopsy findings evallable prior to 24a. Was an autopsy completion of cause of death? 18 Yes 2 No 1 Yes 2 □ No 25. Was case referred to medical 28. Piace of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b Time of

1 Yes 2 No

1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D47380

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David P. Frishberg, M.D. – St. Agnes HealthCare – 900 Caton Avenue – Baltimore, MD/

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

July 1, 1999

29d. Dete signed (Month, Day, Year)

Physician /Medical Examine

Examiner

Physician/Medical

þ

Completed

Be

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Certification:

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Physician

/Medical

Examiner

Funeral

Director

r then "natural", or items 23s or 28s-4 show the Medical Examiner must be notified at

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s filed within 72 hours efter de I Hygiene. other then "natural", or ftern

permit. Peges 1 end 2 should be filed wit. Dependentment of Health end Mental Hygiens Important: If item 27 is marked other the any injury or other traumetic event, that 2006.

Baltimore,

ician and bunal-transit physician the 98 ettending 980 0 the detached signed by to been : has certificate

Box 68760 certificate be The law requires that the deeth of Vital Records, P.O. WALDMAN, PAUL Physician: this Division or Attending death. efter

funeral eral Director; After filled in by the funer Hospital 24 hours within 2

Registrar **DHMH 16 Rev 6/95**

29b. Signature and title of certifier

32. Registrar's Signature

28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Sparker

31. Date filed (Month, Day, Year)

1. Naturai

2 Accident

3 ☐ Suicide

29a, Certifie

4 Homicide

(Check only one)

9 1999

5 Pending

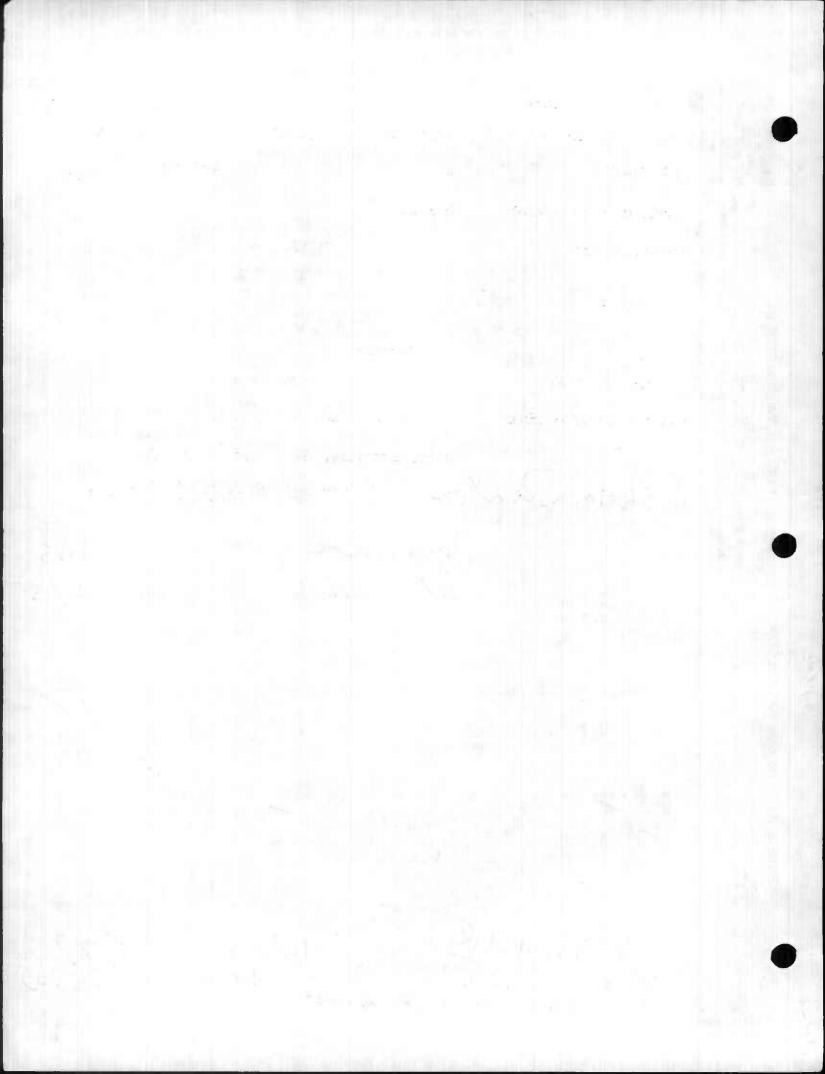
investigation

6 Could not be determined

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JUL 1999 James A. Shares

Physician /Medical	1. Decedent's Name (First, Middle	, Last)										
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Examiner	4a Facility Name (If not institution Mariner Health	give street and num Center of	Great	er Laur	rel		ib. City, Town, Laurel				of Death ce Geor	ges
neral ector	5. Social Security Number 258–24–3862	6. Sex 1 XM 2 ☐ F	7. Age (In yrs. 82	last birthday) Yrs.	If Unde Months	Days	Hours I	Hrs. 8. Da Min. Aug	te of Birth onth, Dey, ust 21,	1916		(State or Foreig
led at	Usual Residence of Decedent 10a. State 10b. County Maryland Anne A	rundel		y, Town or Lo enton	cation						10d.	Inside City Limit
siner must be notified at Funeral Director	10e. Street and Number 1190 Monie Road				10f. Zlp	Code 2	113			g. Citizen of V United		
by 8	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Microced	12. Was Dece Armed For 1 Tes If Yes, Give Year or Da	ces? 2⊠ No e				ispanic Origin an, Mexican, P Specify:	? (Specify Yourdon, Property Rican,	es or No- etc.)	Blac	a - American lok, White, etc.	
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o Be Co	12 17. Father's Name (First, Middle, I Walter H. V						18. Mother's Rosa	Name (First	, Middle, M	la <i>iden Sum</i> am	10)	
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Be	25. Wes case referred to medical examiner?	I be emitted:				Lou	26. Place of	Death (Che	ck only one)		
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Me dwo	29b. Signature and title of certifie	iva Kol	5	M.V.). 29	c. Licens	e number 419	78	29	d. Date signe	d (Month, Day	year)
	30. Name and address of person v	vho completed cause	ot death (Iter	n 23e) (Type,	Print)	1.	1 .	1.			1 / 5	780



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene QQ 917QQ

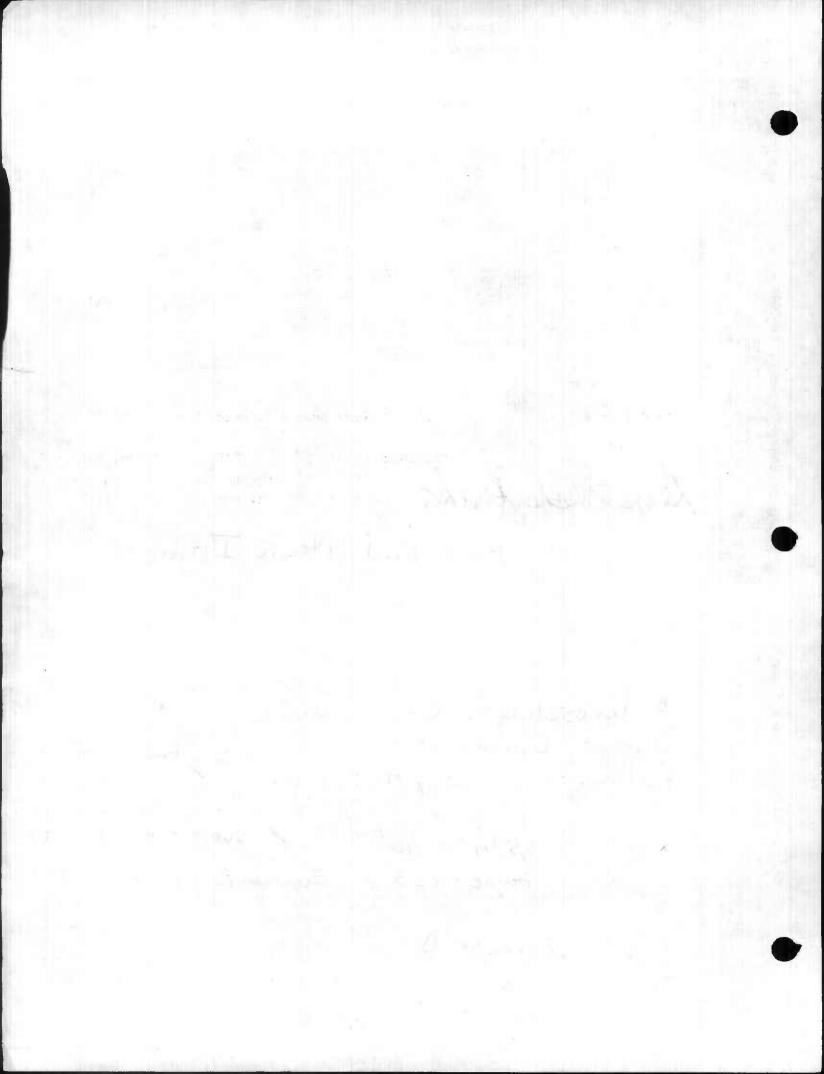
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	State	31. Data filed //	Day, Year)	32. Regist	trar's Signatura		, ,						

DHMH 16 Rev 6/95

State

Registrar

JUL 0 9 1999



1. Decedant's Nama (First, Middla, Last)

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	28s-f	9	10e. Street and Number		1	10f. Zip Code			10g. Citizen of V	What Country	13
	Sa or	Funeral Director	1459 Sussex Road			21221			U.S.A.		
	deati	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forcas?	J,S. 13. Was	Decedant of	Hispanic Origin? (S pan, Maxican, Puar	Specify Yes or N	0- 14. Rec	e - Amarican	
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Baltimore,	pemit. Page Department of Important: If eny Injury or pnce.		21. Signertifit of Funeral Service Licen	E. Lemi		Bruzda	ass of Facility inski Fu	neral Ho	ome, P.A	•	
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			Man CA	all		Da	0907		July 1	0,19	99

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9

Certificate of Death

Reg. No.

2. Date of Deeth Month

4000 Franklin Square DR Bultimore Maryland 21237

3. Tima of Death

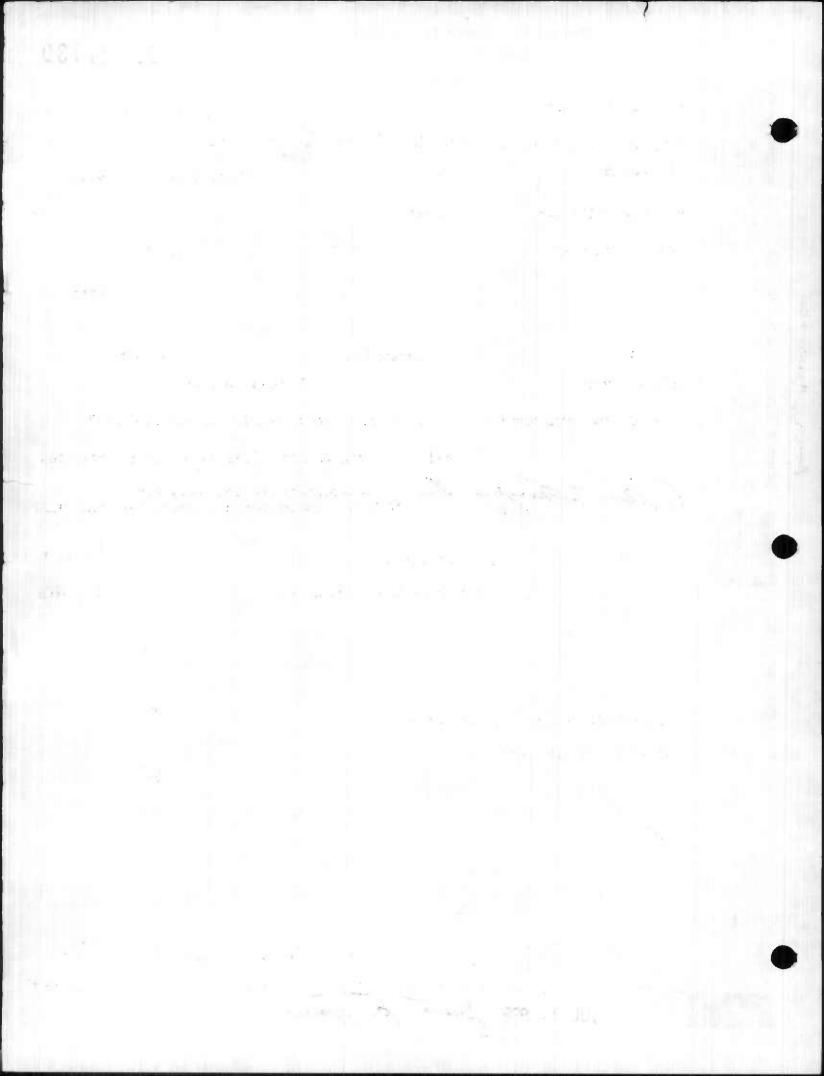
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State Registrar 30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print)

32. Registrar's Signature

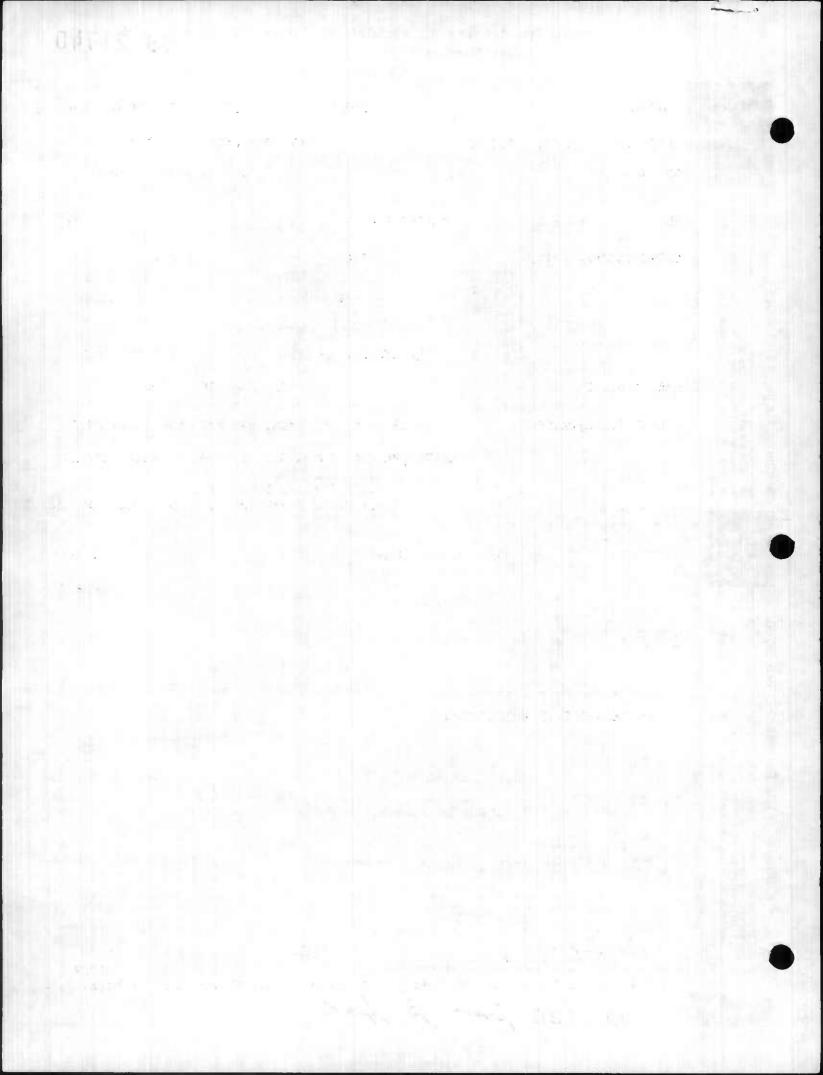
DR Marie Chathan
31. Data filad (Month, Day, Yaar)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Director	10e. Street and Number				10f. Z	ip Code			10g. Citizen of	What Cour	ntry?
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	20a. Method of Disposition 1 Buriai 2 Cremation	3 Demoved from State	Cé	leca of Dispos emetery, crem	sition (No etory or	eme of other ple	eca)	Dete	20c. Location	- City or To	own, Stete
	4 Donution 5 Other (5		BAL	TIMORE	WAS	HING	TON CR.	7/9/99	LAUREI	, MAF	RYLAND
	21. Signatura of Fundral Service	Licansee					ess of Fecility				
	b book	no Aldi	000				NERAL HO				
	23a. Part1. Enter the disease, o shock, or hear leiture. Lis	r complications that cause	d the death	n. Do not ente	or the mo	SAND de of dy	OY SPRING ing, such es cardi	ec or respiretory	AUREL,	MARYI	AND 20707 Approximete
n	shock, or hear feilure. Lis	t only one cause on eech	line.								Interval Batween Onset and Deeth
al	Immediate Cause (Final	CHOI	ANCTO	CARCING)M A						1 VEAD
	disease or condition rasulting in deeth)	e. Choli				۸.					1 YEAR
Jer		SEPS		r es e consequ	uenca o):				1.	WEEKS
Examine	Sequentia the liet ann ditions	b		ras a consequ	Jence of):					WEEKS
Exa	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			20 2 00/10041		·					
edicai	thet initiated events	с.	Due to (or	es e consequ	ience of);					
led	resulting in deeth) Lest		(5)							i	
Physician/M		d								ì	
sicia	Pert II. Other significant conditi	ons contributing to death	but not resu	ulting in the un	derlyina	cause o	iven In Pert i.	23b. Dio	tobacco usa c	ontributa to	o the cause of death?
hys					,3				Yss 2X No		bably 4 Unknown
by P	GASTRIC OUT	LET OBSTRUCT	LION					-			
									s an autopsy ormed?	24b. W	ere autopsy findings reliable prior to
Completed								Peri	o.modi	CO	empletion of causa death?
E								10	Yes 2 No	1[☐ Yes 2☐ No
0	25. Wes case referred to medical	al I					26 Place of D	eeth (Check only			
0 3	exeminer?		ient 2 🗆 I	ER/Outpatient	3 🗆 🛭	OA Ot	hor	Home 5 Ree		ther (Special	fv)
H:	27. Menner of Deeth	28e. Dete of In		28b. Time of		28c. Inju			how Injury occi		"
itio	1 Neturel 5 Pendi 2 Accident invest	ng (Month, D igation	ay Year)	Injury	М		ork?]Yes 2□No				
Certification:	3 ☐ Suicida 6 ☐ Couid	not be 28e. Placa of li	njury - At ho	ma, ferm, stra	at, facto	ory, offica				ber or Run	el Route Number,
ert	4 Homicide	building, e	tc. (Specify	1)				City or To	own, Stete)		
edicai C	29a. Certifier 1 Certifyle (Check only one)	ng Physician: To the bes Examiner: On the besis	of axaminati	wledge, death ion end/or Inv	occurre estigetic	d et the t	ime, dete end ple opinion, deeth oc	ca, end due to the curred at the time	cause(s) end r , dete end pleca	nenner es s , and due t	stated. o the cause(s)
Me	29b. Signeture end title of certific	and manner s		2 ESIDE	u7. 2	9c. Licen	sa number		29d. Date sign	ed (Month	Dev, Year)
	1118-	1-1- MED	ICHIC P	COIPLE							
	Wig for	1 Sport				P	12588		JULY 7	, 199	9
	30. Neme end eddress of person			,							287
	BOYIADZIS, MIC				HOPK	INS	HOSP, 60	I N. WOI	FE ST,	BALTI	MORE, MD
State	31. Dete filed (Month, Day, Year	32, Regis	trer's Signet	ture 4	lo	2/2	/				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 0905 Barnett Joseph /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of University Baltimne Baltimus MD Shock Trauma If Under 24 Hrs. 8. Date of Birth Hours Min. 8. Month, Day. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (Steta or Foreign Country)
 M D 6. Sex Funeral Days 100M 20 F Months 56 217-40-3653 Director 15 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits NA Baltimore W Yes 2 No MD Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 Wyanoke Avenue 21218 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1₺ Never Married 2 Married 1 Yes 2 No Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NA permit. Pages 1 and 2 should be filed will Department of Health and Merital Hygien, importants if health and Merital Hygien, sary injury or other traumetto event, the goos. Gordan Seafood Co 8th Grade Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Mary Barnett Wilson Willie 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 835 N. Collington Avenue Baltimore, Md.21205 Donald Barnett 20b. Place of Disposition (Name of 20a. Method of Disposition Dete 20c. Location - City or Town, Stata Voshell Mem. Gardens 07-13-99 to Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Baltimore, Maryland 21202 MA WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) fasciltis Necrotizina Examiner Due to (or as a consequence of): Examiner rehal disease End stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Disseminated intravascular Coopulation. Physician/Medical Due to (or as a consequence of) Sepsis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contributa to the causa of death? 1 Yaa 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 2 5 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) TMYes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Naturat 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

State Registrar

the Maryland

72 hours after

Hygiene. Hygiene. other then "n

altimore, Maryland 21215-0020

me 23a or 28a-f show must be notified at

than "natural", or items 23s or the Medical Examiner must be

physician and the buriel-transit

signed by the e

been si

To the Hospital or Attending Physicien: within 24 hours effer deeth.

To the Funeral Director: After this certifical completely filled in by the funeral director;

The law requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

DHMH 16 Rev 6/95

29b. Signature and title of certifier

/ lauma 31. Date filed (Month, Day, Year,

TCU.

Baltimbe

29c. License number

MD

4904829

Eric A. Crawles

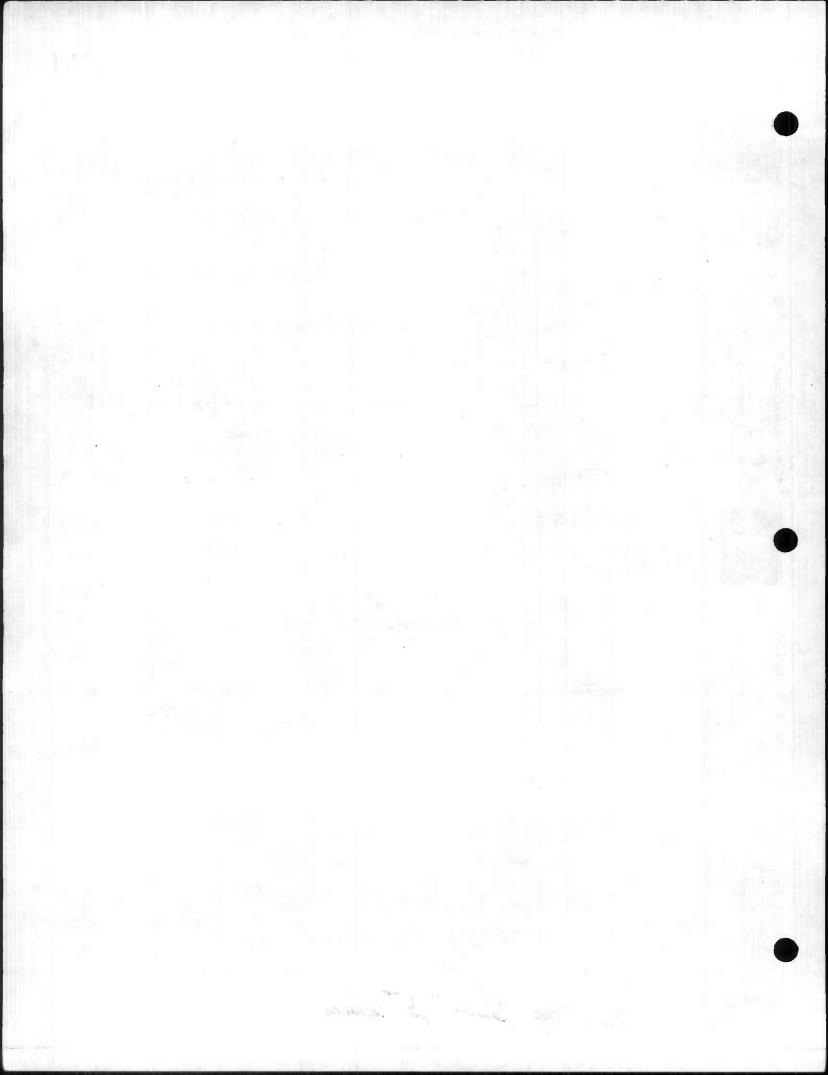
29d. Date signed (Month, Day, Year) 7/10/99

Pelmonary Critical Care Fellow

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shock Trauma



99-3894-510

II	ASP EMS: #23	PART I, 27 PER MEO G 1. Decedent's Name (First, Middle		WR.	C	ertificate	e of I	Death	2. Data of	Reg. No.	5 4	3. Time of Death
	Physician /Medical	Joan B	utler						JULY	06 19	Year 999	2316
	Examiner	4a Facility Name (If not institution, UNION MEMORI					1	4b. City, Town, o			y of Death A	
	Funeral Director	216-62-4984	6. Sex 1 □ M 2 □ 🏋 F	7. Age (In yrs. 43	last birthd	Months	1 Year Days	Hours Mir		Birth <i>Day, Year)</i> 0 – 5 6	9. Birthplac Country MD	e (Stete or Foreign)
Aerylend	r show	Usual Residence of Decedent 10a. Stata 10b. County M.D. N	Α		ty.Town or Balti	Location					10d	Inside City Limits XIX Yes 2 □ No
with the	r Hems 23s or 28s-fe other must be notified Funeral Director	10e. Street and Number 948 Montpeli	er Stre	eet		10f. Zip 21	Code 218			10g. Citizen of USA		?
VIZIS-0020 within 72 hours effer deeth with the Meryland	by by	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Fo	2 🛛 No iva	J,S. 1	3. Was Deced If Yes, spec	ify Cuba	lispanic Origin? (an, Mexican, Pua Specify:	Specify Yes or rto Rican, etc.)	Ble	ce - American ick, White, etc	
21215-0020 d within 72 hours of	tal Hygiene. d other than "naturn event, ins Hisses Be Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (N.A.		lif	cedent's Usua ive kind of wor b. DO NOT us ashier	e retired	nation during most of w d)	orking	16b. Kind of B	asiness/Indus	
land 2	Mental Hygis arked other artic event, tr To Be Co	17. Father's Name (First, Middle, L George						18. Mother's N		fle, Maiden Sumei Edward	me)	
Maryland	27 le mari	19a. Informant's Neme/Refetionsh Denise Jone								nber, City or Town		ode) 21218 ,Maryla
Peges 1 e	int: If item ary or other	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			cemetery, i	sposition (Nameremetory or of	her pled	∞) Gardens	Date 07-13	20c. Location	- City or Town andalk	
Balti Pemit.	Departr Importa any inju	21. Signature of Funeral Service 1	icensee	1		22. Neme en	Mar	ess of Facility B	altimo 1101	re, Mary E. Nort	rland h Ave	21202 nue
1.	ysician Vedical	23a. Part1. Enter the disease, or a shock, or heart fellure. List of the control		caused the dee each line.		enter the mode	e of dyir	ng, such as cardi	ac or respiretory	arrest,	in in	pproximate Itervel Between Inset and Death
	aminer	resulting in death)	a			sequence of):						
60, be executed	buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b	Due to (or es e con	sequence of):						
	o phy the	that initiated events resulting in death) Last	d	Dua to (or as a con	sequence of):						
thet the deeth certificate	d by the eteche	Part II. Other significant condition HYPERTENSIVE CARDIO			sulting in th	e underlying co	ause giv	ven in Part I.		id tobacco use co		he cause of death? bly 4 Unknown
of Vital Records, P. Physicien: The lew requires that	s been s 2 should pieted								pe	as an autopsy enformed?	availe	autopsy findings able prior to bletion of cause eth?
tal R	director, page	25. Was case referred to medical						26 Place of D	eath (Check on	¥Yes 2□No	pso	Yea 2□ No
Of VIta Physicien:	To B	axaminer? XXYes 2□ No	Hospitef:	Inpatient 2] ER/Outpa	tient 3CXDO	A Oth	her		esidence 8 🗆 Ot	her (Specify)	
		27. Manner of Death 1 Natural 5 Pending investig	etion	of Injury oth, Day Year)	28b. Tim Inju	e of 2 y M	Bc. Injui Wor	ry at rk? Yes 2 ☐ No	28d. Dascrit	e how injury occu	irred	
5 8	is after deeth. el Director: After t led in by the funer: Certification:	3 Suicide 6 Could n 4 Homicide determin	ned 288. Placi	e of Injury - At h ling, etc. (Speci		sfreet, factory	, office			n (Street end Num Town, Stete)	ber or Rurel F	Route Number,
Hospital	Funer Funer Ical	29e. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the xaminer: On the b	best of my kno pasis of examina	owledge, de etion and/o	eath occurred a rinvestigetion,	in my o	me, date and pla opinion, deeth oc	ce, end due to t curred at the tin	ha causa(s) and m ne, date end place	nanner as stat , and due to th	ed. ne cause(s)
To the	To the comple	29b. Signature and title of certifier	1 00					se number M.E		29d. Dete sign		ay, Year)

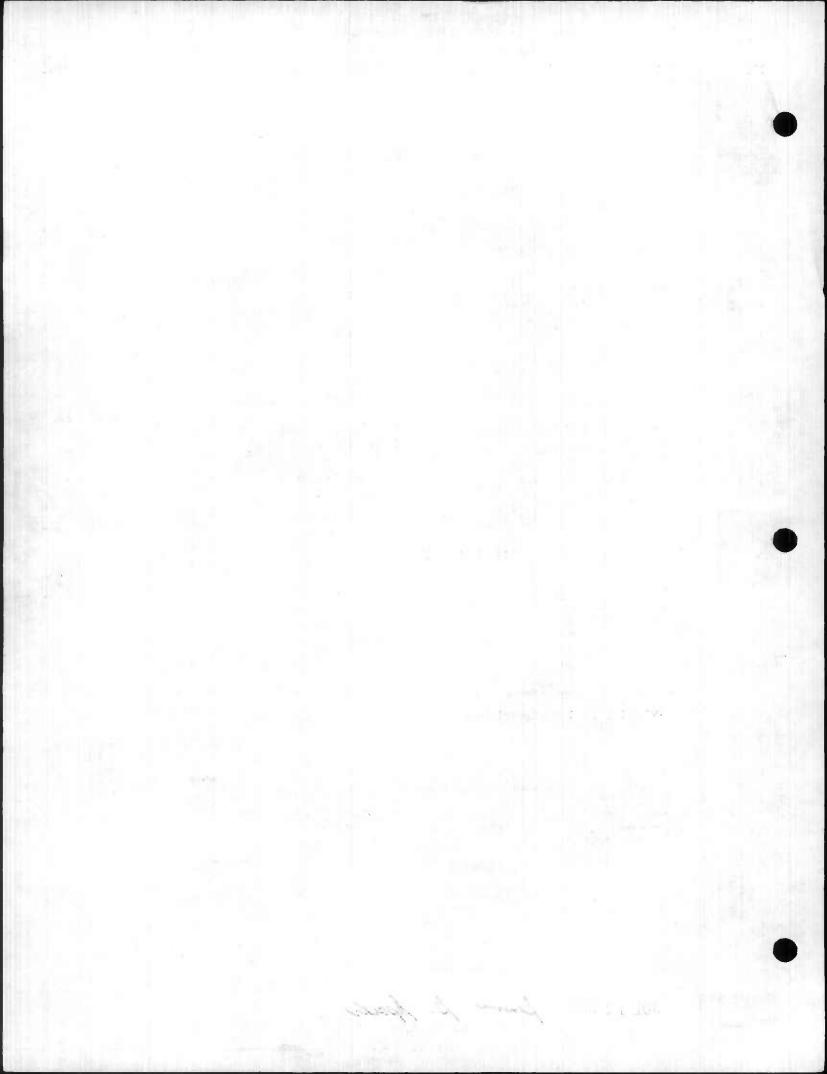
State Registrar

O.C.M.E

JULY 07,1999

OS of particular completed cause of death (Hem 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July **Physician** 02, 1999 06:12 pm Lillian Blackston /Medical 4a Facility Name (If not institution, give square and number) . City, Town, or Location of Death Examiner Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1□ M 2以F Director 214-76-1736 M.D. 90 10 03 08 Usual Residence of Deced 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits TY Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Herrie 23a 3939 Penhurst Ave 21215 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes & No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1X Never Merried 2 Married "natural", or 1 ☐ Yes 2 No Specify: Specify:White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 96 2 should be a and Mental I Unknown Unknown 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other tras gags. Vinni Baxter-Social Worker 3939 Penhurst Ave, Baltimore Md 21215

Date 20b. Place of Disposition (Name of Date 20b. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Pages sert of h 1 Burial 2 Cremation 3 Removal from State King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 7/10/99 Randallstown, Md ture of Euperal Service Licens 22. Name and Address of Facility March F/H West

4300 Wabash Ave, Baltimore Md

short, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner physicien end the burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be Physician/Medical Due to (or as a consequence of): 088 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yaa 2 No 3 Probably 4 Donknown p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen s 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28h Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral 28c. Injury et Work? 5 Pending 1 DNetural 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated. edical (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

Box 68760.

P.0.

Records,

of Vital

Division

JUL 1 2 1999

Name and address of person who complete Boelas, 2461

31. Date filed (Month, Day, Year)

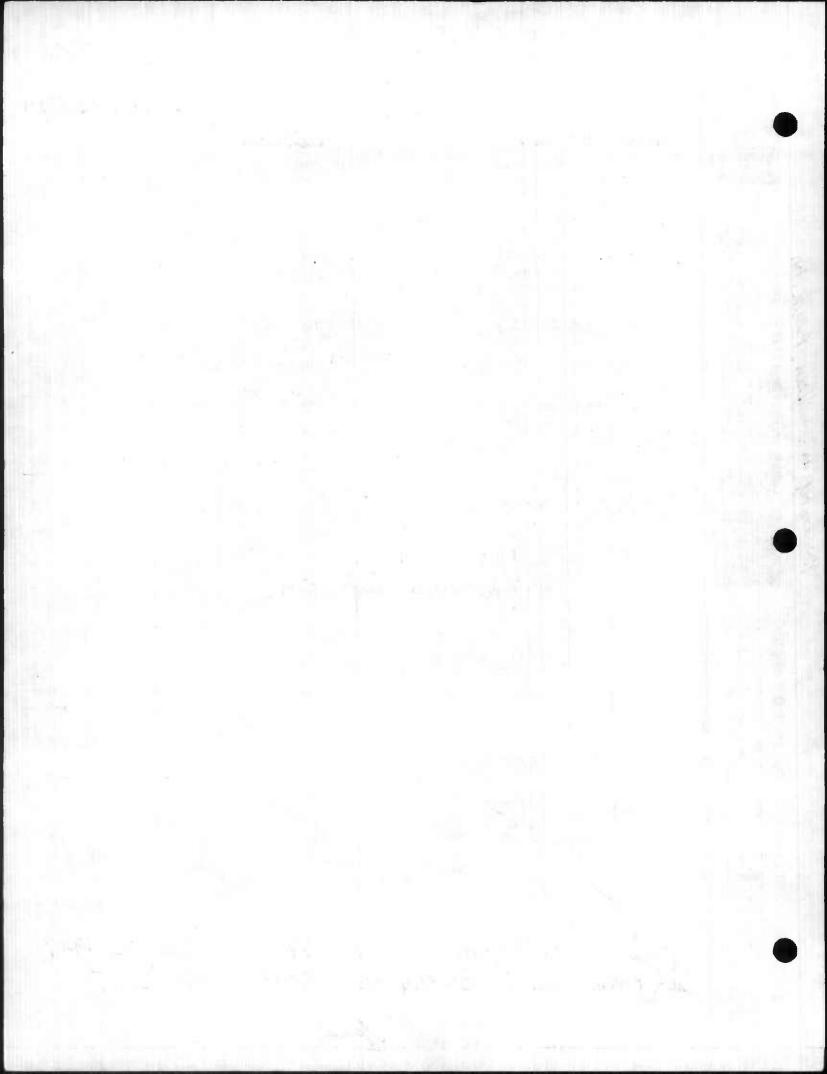
32. Registrar's Signature

Blivedly A

G. Sports

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Ballimore, MD.

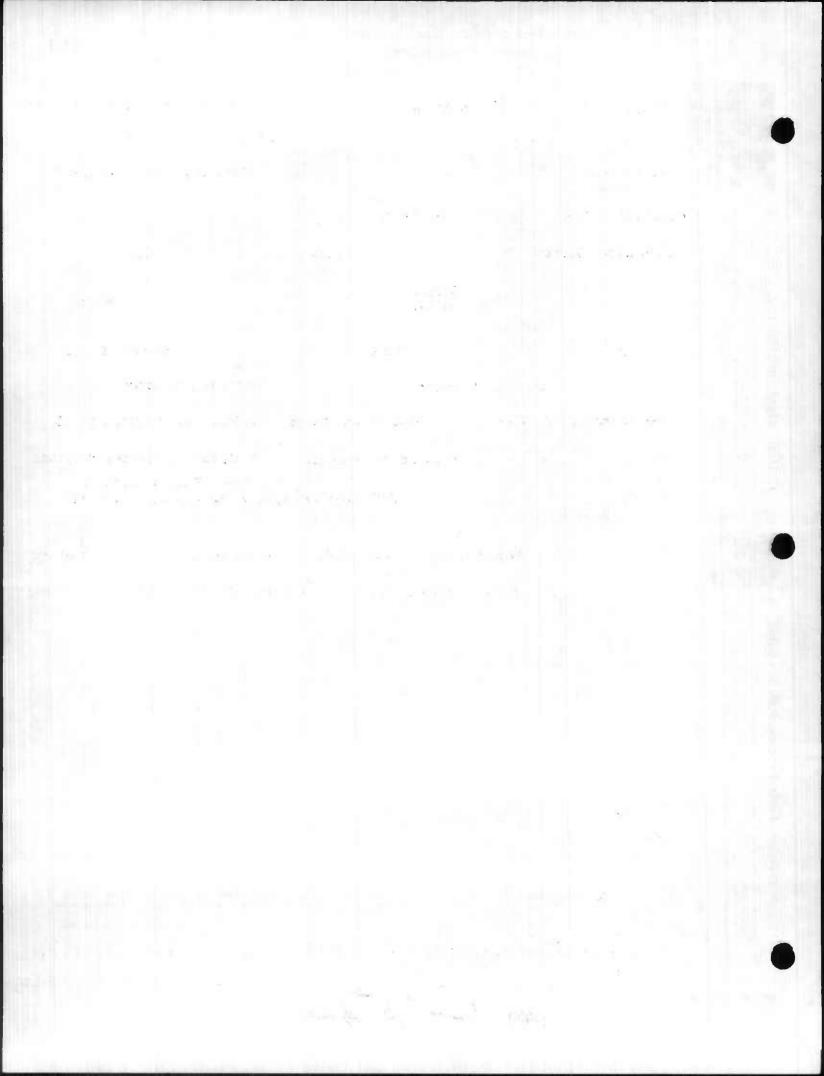


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death 3. Tima of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** 4:20 AM BRANDNER 1999 FRANCIS JULY /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner BALTIMORE HOSPITAL CENTER HARBOR N/A 8. Dete of Birth (Month, Day, Yeer) Jan. 30, 1928 If Under 1 Yeer If Under 24 Hrs. Birthplace (Stete or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** 1.X M 2□ F Months Devs Hours 216 24 2132 71 Maryland Director Usuel Residence of Decedant 10d. Inside City Limits with the Marylenc 10c. City, Town or Location 10a Stete 10h County ? is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at Maryland N/A Baltimore 1 Yes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3606 Ninth Street 21225 U.S. Funeral deeth 12. Was Decadent Ever in U.S. Armed Forces? 12□ Yes 2□ No Korean If Yes, Give Year or Dates: Conflict Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Bleck, White, etc. Pages 1 and 2 should be filled within 72 hours after sent of Heelth and Mental-Hyglene.
nt: If item 27 is marked other than "natural", or ite 1 ☐ Never Merried 210 Married 1 ☐ Yes 2 No Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elemantary/Secondery (0-12) College (1-4or 5+) Clerk Grocery Store 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Gertrude Adelharot Frank A. Brandner 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Retationship (Type, Print) Joan Brandner 3606 Ninth Street Baltimore, Maryland 21225 altimore, 20b. Pleca of Disposition (Neme of cametary, cremetory or other plece) 20a. Method of Disposition 20c. Location - Cltv or Town, State 1X Buriel 2 ☐ Cremetlon 3 ☐ Removal from State Injury or Department Inportant: If 9/10/99 Baltimore, Maryland Holy Cross Cemetery 4 ☐ Donetion 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximata Interval Between Onsat end Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) PLEURAL EFFUSION MALIGNANT Examiner CARCINOMA OF LUNG Examiner SMALL that the deeth certificate be executed ician and buriel-trens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted avants resulting in daeth) Lest Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the Dua to (or as a consaquance of): 950 23b. Did tobacco use contribute to the cause of death? the bed Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. signed by t 1 XY00 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to Completed 24a. Was en eutopsy completion of cause hes 20 No 1 TYes 2 No 1 Yes 25. Was case referred to medical examinar? Be 26. Piace of Deeth (Check only one) Hospital: Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residenca 8 Other (Specify) P 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Dey Year) funeral 28c. Injury at Work? 28d. Dascribe how Injury occurred 27. Manner of Death 28b Time of Certification: Hospital or Attending 1 Naturat 5 Pending investigation after death. Director: Aft 1 Yes 2 No 2 ☐ Accident 6 Could not be datamined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homloide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stetad. edical 29a. Cartifier To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certifie P 13 170 MEDICAL INTERN 30. Name and eddress of person who complated cause of deeth (Item 23a) (Type, Print) STREET, BALTIMORE, MARYLAND 21225 SAMEER BADE, N 31. Date filed (Month, Dey, Year) MD 3001 SOUTH HANOVER

32. Registrar's Signature

DHMH 16 Ray 6/95

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Date of Death 3. Time of Death 5:00 PM Clara CAPTER U64 4a Facility Nama (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death BOIL HORE MANOR CAVE of ROLAND ff Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) 88 1 M POF 229-12-8030 **Usual Residence of Decedent** 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits BAIDMIK Per Tes 2 No Mary brus 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? BELVEDERE 21215 3341 W. USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Give Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian 11. Merital Status Bleck, Whita, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: USA 32 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry PRIVAK Elementary/Secondary (Q-12) Cotlege (1-4or 5+) HOUSEKEEPOR 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) WALTER CHARLITE MADISM 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 3341 W. BOWEDERE ARE BALLINGIE, AmillE Holloway Brasp Doughhr 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 7-13.99 Burial 2 Cremetion 3 Removet from State 4 Donation 5 Other (Specify) MEMORIAL GONDERS 23. Name and Address of Facility CHATMAN 52 40 RCL STE RSTUM R BOHMER Have Jones - HARRIS Konord 21. Signature of Funeral Service Licenses Havin Jones 012/1 23a. Part1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on aech lina. Approximata tntarvel Between Onsat and Death Immediate Cause (Fine) 1-2 months disease or condition resulting in death) 28 m. 6 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 | Yee 2 | No 3 | Probably 4 | Unknown

Physician /Medical Examiner

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signed by the a

page 2

After this funeral

24 hours after death.

within 2 the the

Hospital

filled in by

Certification: To

Medical

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Records.

Division of Vital or Attending Physicien: **Physician**

/Medical

Examiner

Director

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Completed

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Funeral

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d 2 should be filed within 72 hours efter death with the Manylan It and Mental Hyglene.
The marked other than "natural", or Nema 23a or 28e-f ahow traumatic avent, the Medical Essenties and the notified at

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permit. Pege Department o Important: If any Injury or page.

21215-0020

Baitimore, Maryland

Examiner Physician/Medical þ Completed Be 25. Was casa refarred to medicat examiner?

24a. Was an autopsy performed? 2 1 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury et Work?

1 Naturat 5 Pending investigation 1 Yes 2 No 2 Accident

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 ☐ Suicide 28e. Plece of tnjury - At home, farm, street, fectory, office building, atc. (Specify) 4 Homicide

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier (Check only one)

29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

30 Name and addrass of person who completed causa of death (Item 23a) (Type, Print)

3 CHLUERT ST # 655 BALT MD 21218

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature **ORIGINAL**

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CHIP

State

DHMH 16 Rev 6/95

Registrar

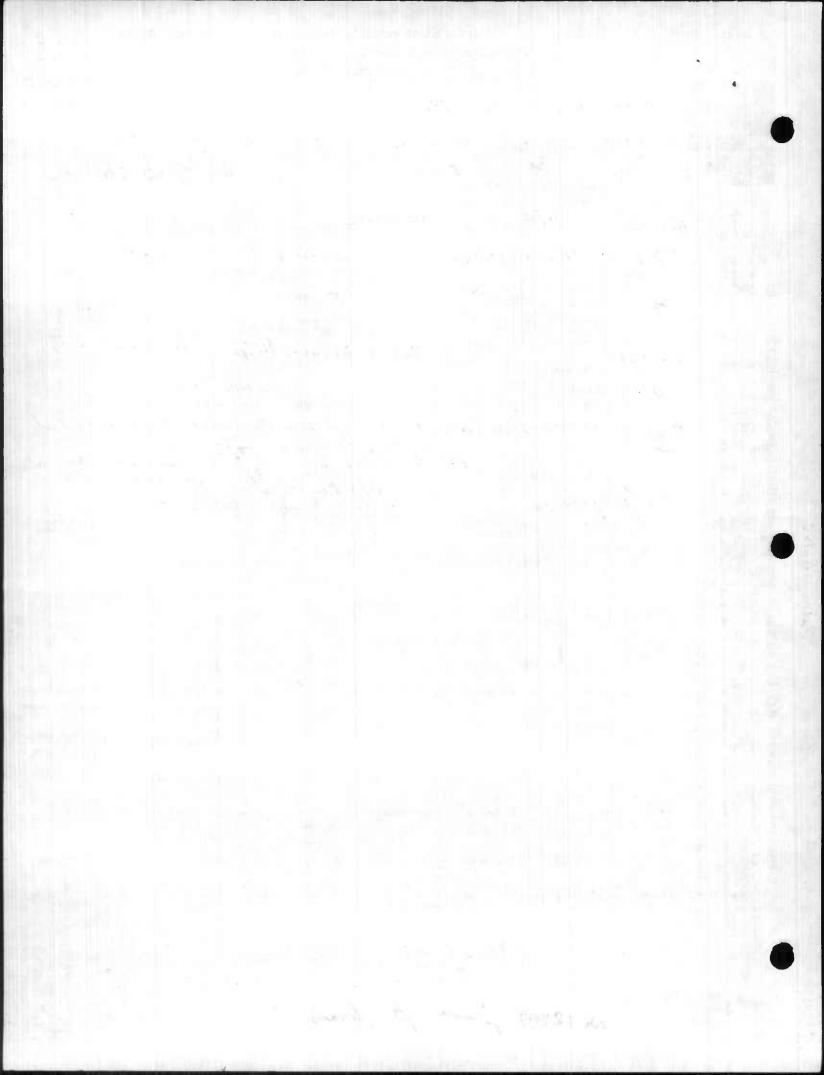
31. Data filed (Month, Day, Yaar)

30. Name and addrass of person who complated ceusa of daeth (Itam 23a) (Typa, Print)

32. Registrar's Signatura

m.D.G

reneral Hospital



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death July 8:50am 06, Katie Mae Coleman 4s Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1308 Goodwood Avenue Baltimore | H Under 1 Year | H Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | 05-08-12 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 AL • 10 M 20 F 87 220-20-6221 Yrs. **Usuat Residence of Decedent** 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 No Yes 2 No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 USA 1308 Goodwood Avenue 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2⊠ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: Black X⊠Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) t6b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) in & out of home Days work 6th Grade 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Pinkey Edwards Thomas Mooney 19a. tnformant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1308 Goodwood Avenue Baltimore, MD. Mary Coleman Johnson 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stete Parkwood Cemetery 07+09-99 Baltimore Co, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Service Licensee Beman WM.C.March FH 1101 E. North Avenue romour 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart lailure. List only one cause on each tine. Approximate Interval Between Onset end Death 2 months CANCER OF THE COLON Immediate Cause (Final disease or condition resulting in death) Dua to (or as a consequence of) Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? DIABETES MELLITUS INSULINDEPENDENT 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy lindings available prior to 24a. Was an autopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medicat examiner? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

Physician/Medical þ Completed

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Medical Certification: To

Physician

/Medical

Examiner

Director

Funeral

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Pages 1 and 2 should be filed within 72 hours efter death with the Meryles nent of Health and Mentel Hyglena.
Int: If Nem 27 is marked other than "natural", or hams 23s or 23a-f ehow lay or other treumatic event, the Medical Examinar must be notified.

permit. Page Department of important: if eny injury or poca.

Physician

/Medical

Examiner

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page 2

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After

after death.

24 hours a Funeral Hospital

within 2 ŝ

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21215-0020

Baltimore, Maryland

Box 68760.

Division of Vital Records,

or Attanding Physician:

6 Could not be detarmined 3 Suicide

28l. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of ourfrier

D0015462

29c. License number

29d. Date signed (Month, Day, Year)

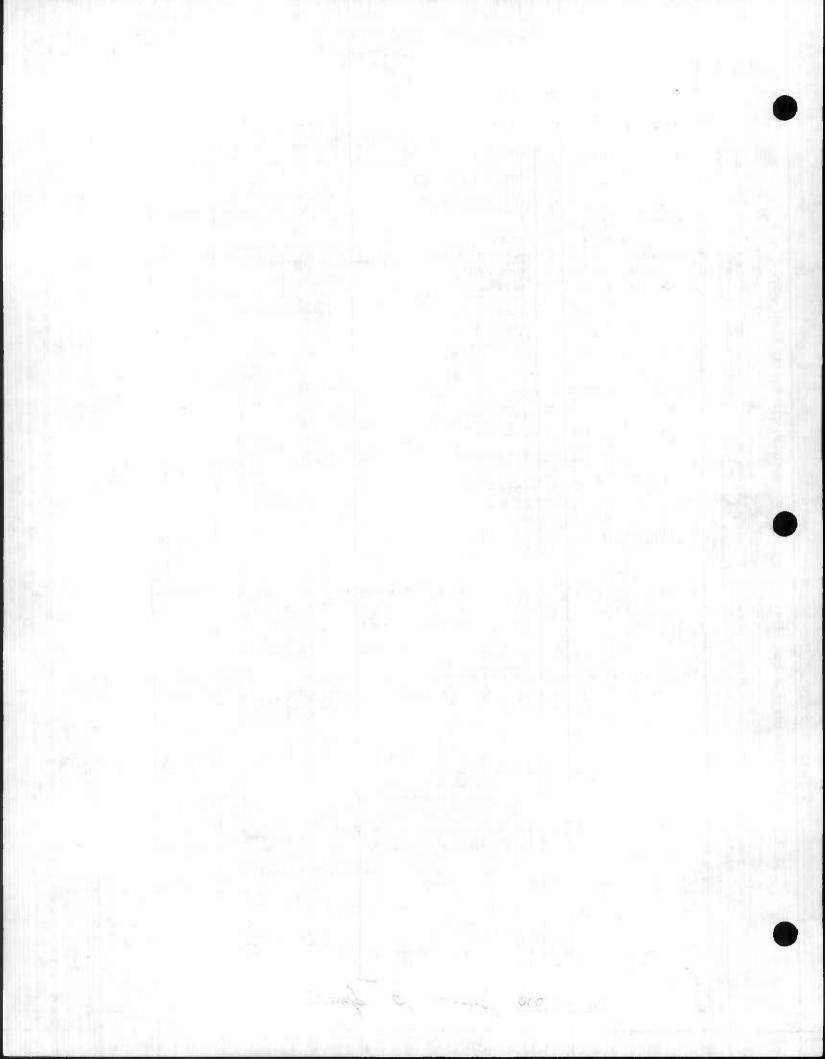
30. Name and eddrass of person who completed causa at death (Item 23a) (Type, Print)

300 E. 33nd St MIGUEL KARACUSCHANSKY M.D. BALTO. HD. 21218

State

Registrar **DHMH 16 Rev 6/95**

32. Registrar's Signature 31. Date fited (Month, Day, Year)



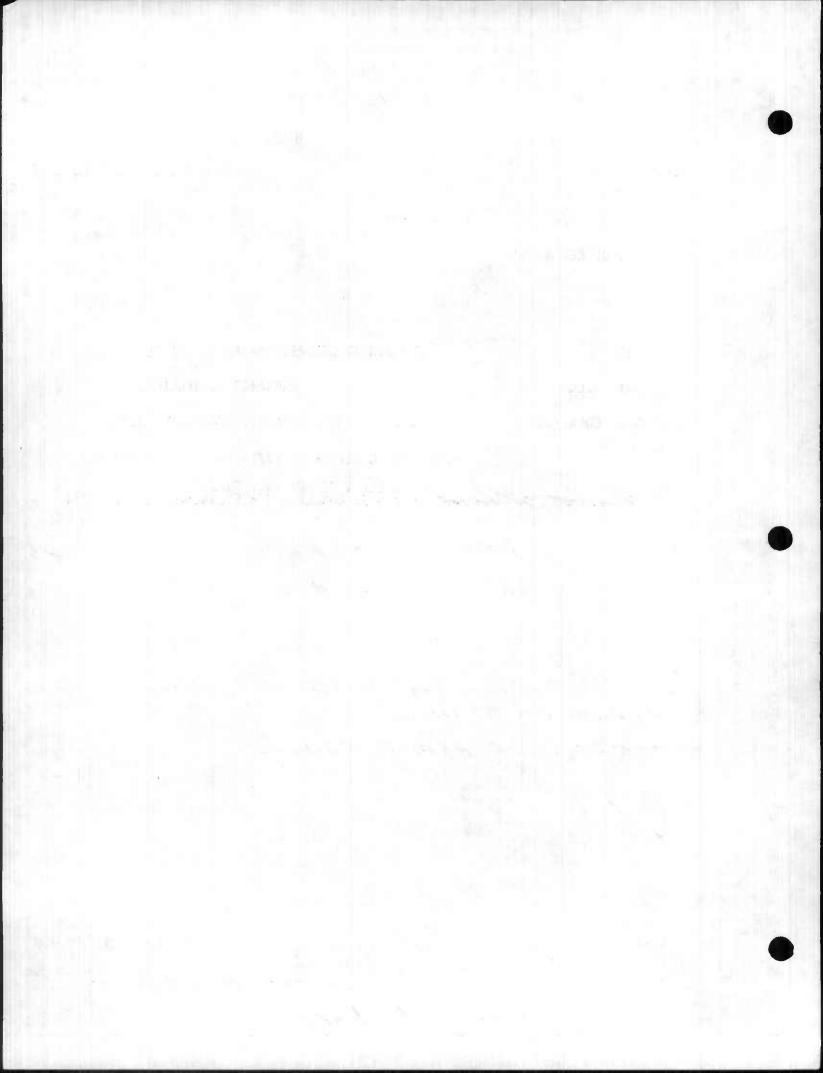
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death JULY, 08,1999 CATHERINE **Physician** COOKE 3:30 PM /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** CHURCH HOME HOSPITAL BALTIMORE If Under 1 Yeer 8. Date of Birth (Month, Dey, Year) June 12,1913 If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** 1□M 2XF Days Months Hours PENNSYLVANIA Yrs. 212-22-9289 86 **Director** Usual Residence of Deceden 10a. Stete 10c. City, Town or Location 10d. Inside City Limits tXXYes 2□No r than "natural", or items 23s or 28s-f s the Medical Examiner must be notified Directo n/a BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1024 S. DECKER AVENUE 21224 Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 N No ff Yes, Give Yeer or Detes: 14. Rece - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 Specify: WHITE 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) EMPLOYMENT SECURITY MANAGER STATE OF MARYLAND 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) hit. Pages 1 and 2 should be Its antment of Health and Mental H ortant: If them 27 is marked oth injury or other traumetic even Be Lo HENRY WILL MARGARET J. WILLIAMS 19a, Informent's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONALD H. COOKE/SON P.O. BOX 1898, OCEAN CITY, MARYLAND 21843 20e. Mathod of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetery or other plece) 20c. Location - City or Town, Stata 1XX Burial 2 Cremetion 3 Removel from State 7/13/99 4 ☐ Donetion 5 ☐ Other (Specify) GRANDVIEW CEMETERY JOHNSTOWN, PA. 21. Signeture of Funerel Service Licensee 22. Neme end Address of Fecility
LILLY & ZEILER INC. FUNERAL HOME
700 S. CONKLING STREET, BALTIMORE, MD. 21224 23a. Part1. Enter the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximeta Intervel Batween Onset and Deeth **Physician** EMBOLIC 3TROKE

Dua to (or as a consequence of): /Medical Immediate Cause (Fine) diseese or condition resulting in death) Examiner Examiner DARTERIOSCLEROSIS physician and s the burial-transit Sequantially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medicai Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown RIAL PIBRILATION à 24b. Wara autopsy findings eveilable prior to completion of cause of death? Completed 24e. Wes an autopsy performed? CONGESTIVE HEART PAILURG 1 Yes 20 No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: 10 Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Menner of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? e Hospital or Attending P n 24 hours after death. e Funeral Director: After t After 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 12/ Certifying Phyelclan: To the best of my knowledge, daeth occurred at the time, dete end place, end dua to tha cause(s) and mannar as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, daeth occurred at the time, data end place, and dua to tha cause(s) end manner stated. (Check only one) To the To the F 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who completed cause of deeth (Itam 23a) (Type, Print) HOSPITAL, BACT. MO CHUNCH M.D. 31. Data filed (Month, Day, Year) 32. Registrer's Signeture State Registrar 2 perces



99-3877-510 B.K.S

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State of Maryland / Department of Health and Mental Hygiene

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ITEMS: #23	
Physician /Medical Examiner	

Funeral

Director

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Item 2.

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Pages 1 and 2 should be 1 sent of Haaith and Mental I int: If Item 27 te marked of

the Maryland

72 hours after deeth

filed within

Baitimore, Maryland 21215-0020

11. Marital Status

Director

Funeral

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Completed

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1. Decedent's Nams (First, Middle, Last) Leon Davis 4a Facility Name (If not institution, giva street and number)

PART I, 27, 28A-F PER MEO G773 7-14-99 WR. Certificate of Death

2. Date of Death 3. Tims of Death Month Day 6, 1999 0615 AM JULY 4b. City, Town, or Location of Death 4c. County of Death

1617	NORTH CA	LVERT STE	REET		BAL'	LIWOI	RE	
5. Social Securi	ity Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under		8. Data of Birth	9. Birthplaca (Stata or Foraign
216-6	58-5723	1□ M 2□ F	4.1 Yrs.	Months Days	Hours	Min.	(Month, Day, Year) 8 – 1 9 – 5 7	Washington ^C
Usual Resident	e of Decedent							"asiiziigeon
10a. Stata	10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
MD			Baltimo	ore				1√2 Yas 2 No

MD 10e. Street and Number N. Calvert Street 1617

1 Never Married 2 Married

17. Father's Nama (First, Middle, Last)

10f. Zip Code 21202 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14 Race - American Indian Black, Whita, atc. Specify: Black

10g. Citizen of What Country?

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2.☐ No If Yes, Give V Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

1 Yes 25 No Specify:

Paint Factory 18. Mother's Nama (First, Middle, Maiden Surnama)

Balto. MD

Approximate Interval Between Onset and Death

16b. Kind of Business/Industry

Nathaniel Davis 19a. Informant's Name/Relationship (Type, Print)

4 Donation 5 Other (Specify)

Louise Hunter 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)

2235 Pelham Avenue 21213

Nadine Davis 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

20b. Place of Disposition (Nama of cametery, cremetory or other p King Memorial Park

Supervisor

20c. Location - City or Town, Stata 7-10-99 Randallstown, Md.

21. Signature of Funeral Service License

22. Nama and Address of Facility

Jeff Miller Funeral Home 1639N. Broadway 23a. Part. Eries the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, affect, or heart failure. List only one cause on each line.

Physician /Medical Examiner

physician and the burial-transit

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Affer

To the Hospital or Autorians within 24 hours after death. To the Funeral Director; After the funeral Miled in by the fur

The lew requires that the death certificate be executed

Box 68760.

P.O.

Records,

of Vitai Physician:

Division or Attending Physician/Medical Examine

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Completed

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Medical Certification:

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediata Cause (Final disease or condition resulting in death)

NARCOTIC INTOXICATION Due to (or as a consequence of)

Due to (or ss e consequence of)

Due to (or as a consequence of):

in Part	1 1.
	in Par

23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Wera sutopsy findings svailable prior to completion of cause of death?

1X Yes 2□No 26. Place of Death (Check only one)

1 Nas 2□ No

25.	Was case referred to medic sxaminer?	at
	Yes 2□ No	
-	44 45 4	

5 Pending investigation 6 X Could not be

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury FOUND: 7-6-99 28b. Time of Α OUNDING 6:00

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home XX Residence 6 Other (Specify) 28c. Injury at Work? М 1 Yes X No

28d. Describe how injury occurred SUBJECT INGESTED DRUGS

28f. Location (Street and Number or Rural Route Number, City or Town, State) 617 N. CALVERT ST.

29a. Certifier (Check only one)

1 Natural

3 ☐ Suicide

2 Accident

4 ☐ Homicide

BALTIMORE, MARYLAND FOUND AT HOME 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as ststed.

XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

O.C.M.E

29d. Data signed (Month, Day, Year) JULY 6, 1999

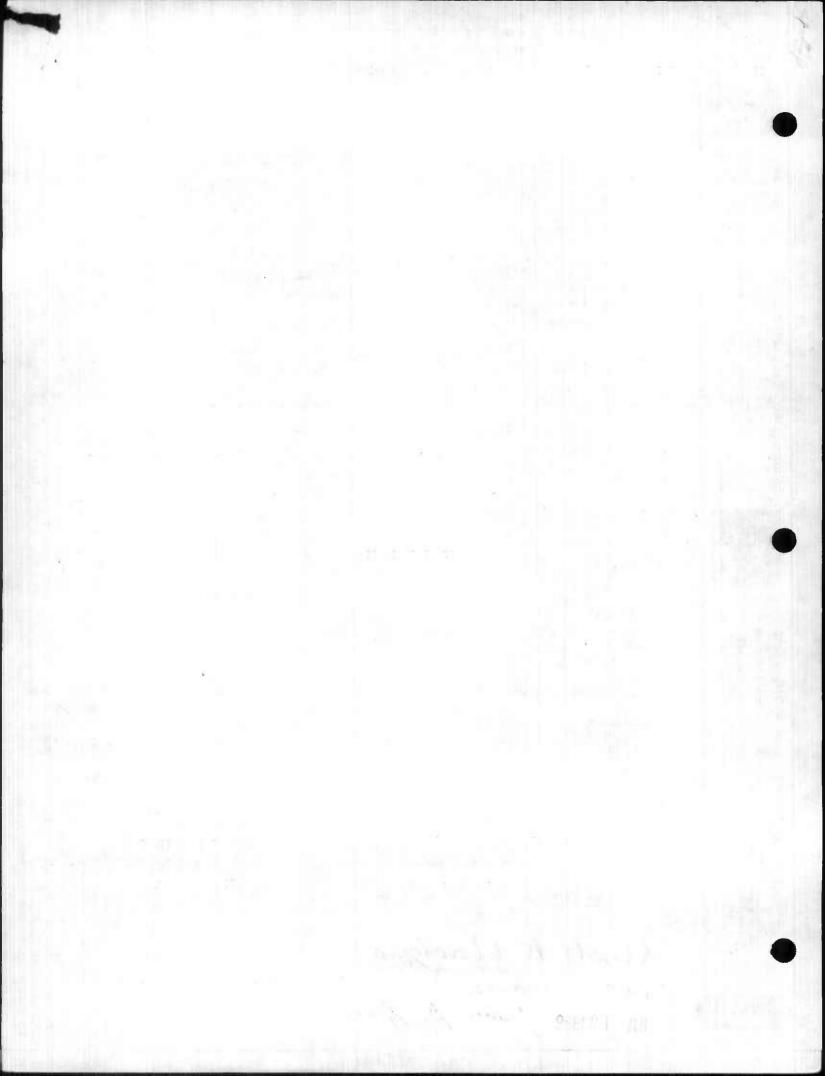
30. Name and address of person who completed cause of death (Nem 23%) (Type, Print)

Street, Baltimore, Maryland 21201 Stephen S, 31. Date filed (Month, Day, Year) Radentz

State Registrar

1 2 1999

32. Registrar's Signature oocks!



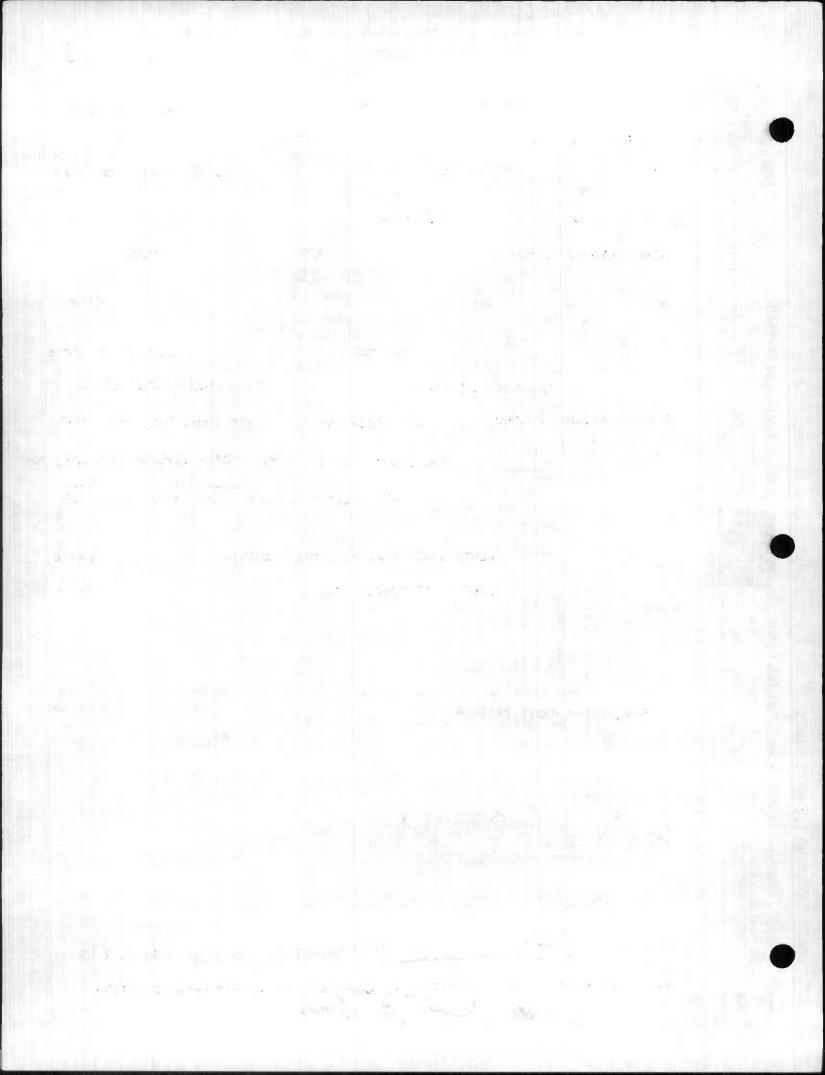
State of Maryland / Department of Health and Mental Hygiene 9

artment of Health and Mental Hygiene) 9 2 75 (

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Physician /Medical	١	Decedent's Name (First, Mid	dle, Las	-	orie E	vely	n Fı	rench				2. Dete of De Month July	[Day 7 1	Year 999		of Death
Examiner		st - Agnes Ho			mber)					4b. City, To Balt		ocation of Death		c. County	-		
Funeral Director		S. Sociel Security Number 218 12 7224	6. Se	x □M 2180 F	7. Age (In 74		rthday) Yrs.	If Under Months			24 Hrs. Min.	8. Date of Bir (Month, Da Oct. 12	h y, Yea	1924	9. Birthi Cou Ma	place (Sintry) ry1a	ate or Foreign
D R	-	Usual Residence of Decedent 10a. State 10b. Count	у		10c	. City, Tov	vn or Lo	cation	+						1	10d. insi	de City Limits
to take		Maryland N/	A			Balti	imor	e								150	Yes 2 No
r 28a Irec		10e. Street and Number						10f. Zip	Code				10g.	Citizen of 1	What Cou	ntry?	
230.0		1038 Rockhill	Av	enue					21	229				U.S	5.		
If of Heelth and Mentel Hyglene. If item 27 is marked other than "natural", or items 23s or 25s-f show or other traumatic event, the Medical Exercises rust be notified at or other traumatic event, the Medical Exercises rust be notified at To Be Completed by Funeral Director		11. Marital Status 1 Never Married 2 Ma 32 Widowed 4 Divorce		12. Was Dec Armed Fo 1 Tes If Yes, Gi Year or D	orces? 2 ∑ No ive	In U,S.	1	Was Dece if Yes, spe 1 Yes	cify Cul	oan, Mexicar	n, Puerto	pecify Yes or No Rican, etc.)			ck, White,		
acal acal		15. Decede (Specify only high	nt's Edi	ucation de completed)		168	. Deced	dent's Usu kind of wo	al Occu	pation during mos	t of work	king	16b	Kind of B	usiness/In	ndustry	
nd Mentel Hyglene. marked other than "naturel; imatic event, the Medical Ess To Be Completed by	-	Elementary/Secondary (0-12)		College (escle		during mos				Depar	tmen	t St	ore
Hyglene. ther there		17. Father's Name (First, Middle	, Last)				001	COCI		18. Mothe	er's Nem	e (First, Middle,	_				OIC
Mentel H arked off artic ever To Be			Cl	harles	T. Pr	ince					Ka	therine	A	. Car	lisl	е	
end Men Is marks aumatic		19a. Informant's Neme/Relation	ship (T	ype, Print)		19	b. Mailir	ng Addres	s (Stree	t and Numb	er or Ru	ral Route Numb	er, Cit	y or Town,	Stete, Zij	p Code)	
Heelth e em 27 is other tra		Gregory Welsh	1/1	Nephew		8	04 V	White	Av	enue	L	inthicur	a,	Mary1	and	2109	00
Department of Heelith Processors of Heelith In y Injury or other to 2008.	2	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 🗆 1	Removal from	State	cemete	ery, crer	natory or o	other pla			Date		Location -			
in the same of the		4 ☐ Donation 5 ☐ Other (21. Signatore) of Funeral Service			(len :				ial Pa		7/10/99	G1	en Bu	rnie	, Ma	ryland
Physician /Medical		23a. Part1. Enter the disease, shock, or heart failure.	O CONTRACTOR OF THE PARTY OF TH	dications that one cause on e	ceused the deach line.	deeth. Do						Gonce F ay Balt or respiretory e	im			2122 Appro- Interve	
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MARJORIE E. FRENCH



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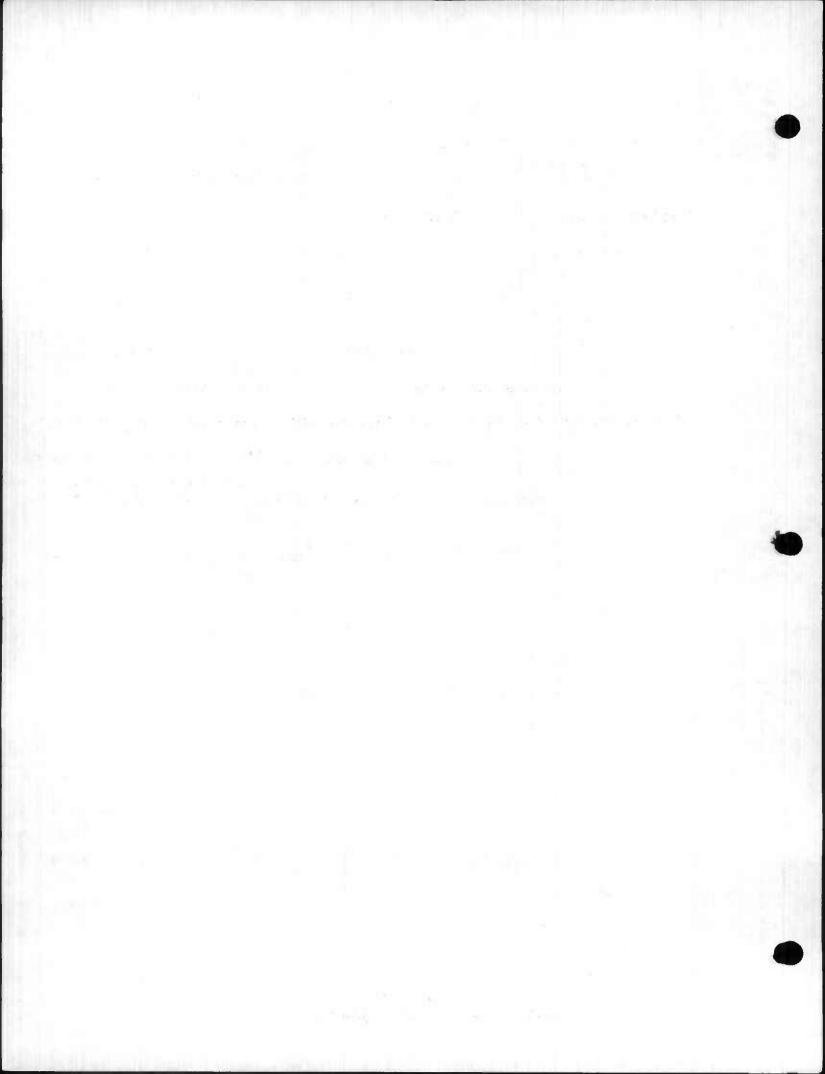
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month 07 Margaret Day 07 **Physician** 34 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Golden Age Guest Sykesville Carroll Home 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Birthplece (State or Foreign Country) **Funeral** 1□M 2 F Months Deys 215-54-0043 Virginia Dilector Yrs. Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours efter deeth with the Marylend nent of Health end Mental Hygiene. int: If Item 27 is marked other than "natural", or Items 23s or 28s-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Maryland Carrol1 Director Westminster 1 Yes 20 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3160 Cardinal Drive 21157 U.S. Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, traumatic event, the Medical Examiner Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2K Married Baltimore, Maryland 21215-0020 by 1 ☐ Yes 2X No Specify Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education if vaniv highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Evelyn Lillian Norten Charles Drayton Maden 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2: Depertment of Health er Important: if item 27 is any injury or other trau once. 3160 Cardinal Drive John J. Ferguson / Husband Westminster, Maryland 21157 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Memorial Park 7/9/99 Glen Burnie, Maryland 4 Donation 5 Other (Specify) 21. Signature Funeral Service Lice see 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 one 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heart failure. List only one cause on each line. **Physician** Now Swell Cell Causes of luy /Medical tmmediate Cause (Finel 13 months disease or condition resulting in death) Examiner The lew requires that the death certificate be executed buriel-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last and Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. attending physiclan Physician/Medical Due to (or es a consequence of): ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Prohimown þ Completed 24e. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of ceuse of death? After this certificate 1 Yes 2 10 No 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Plece of Death (Check only one) Other: 4 Inversing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? Certification: 28d. Describe how Injury occurred 1 Naturat 5 Pending deeth. 1 Tes investigation 2 Accident within 24 hours after deat To the Funeral Director: completely filled in by the 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homleide edicai 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) /unesus 20806 30. Narpe and eddress of person who completed cause of death (Item 23a) (Type, Print) ELASESBURG, MD PATRICK TURNES, NO 1425 LIBORTY

Registrar
DHMH 16 Rev 6/95

State

31. Date fited (Month, Dey, Year)

32. Registrar's Signatu



Division of Vital Records, P.O. Box 68760,

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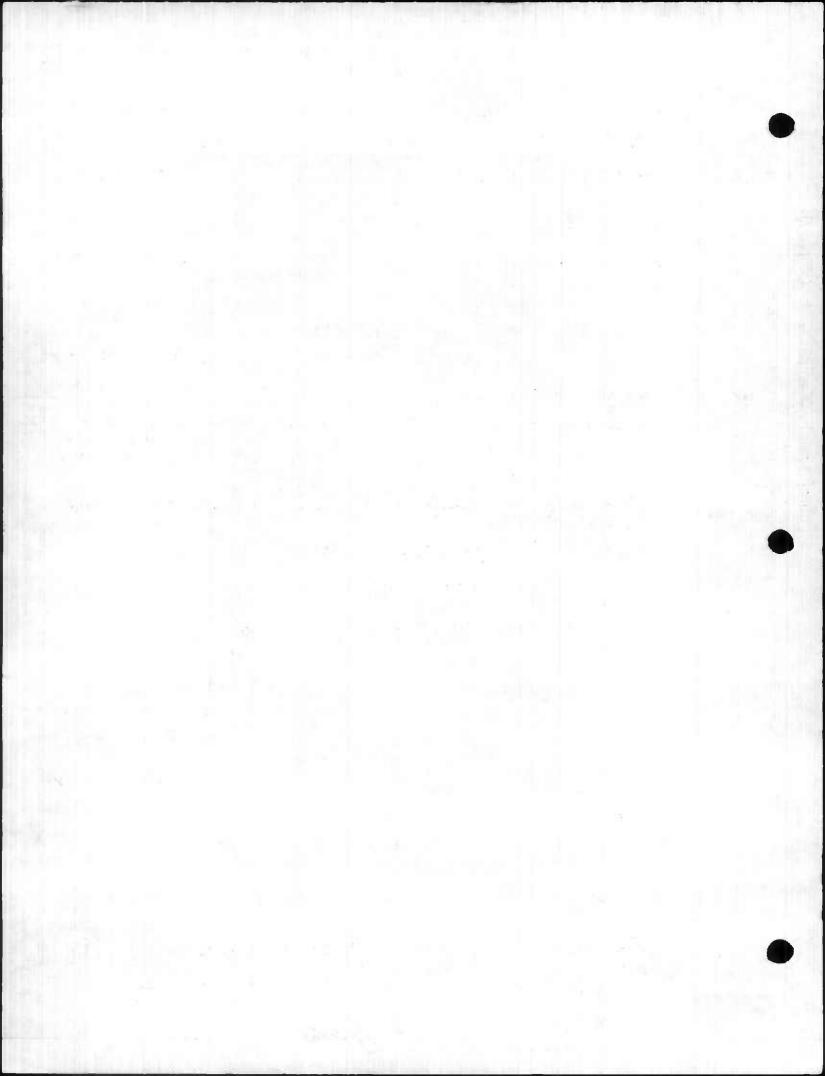
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who completed cause of death (ftem 23a) (Type, Print)

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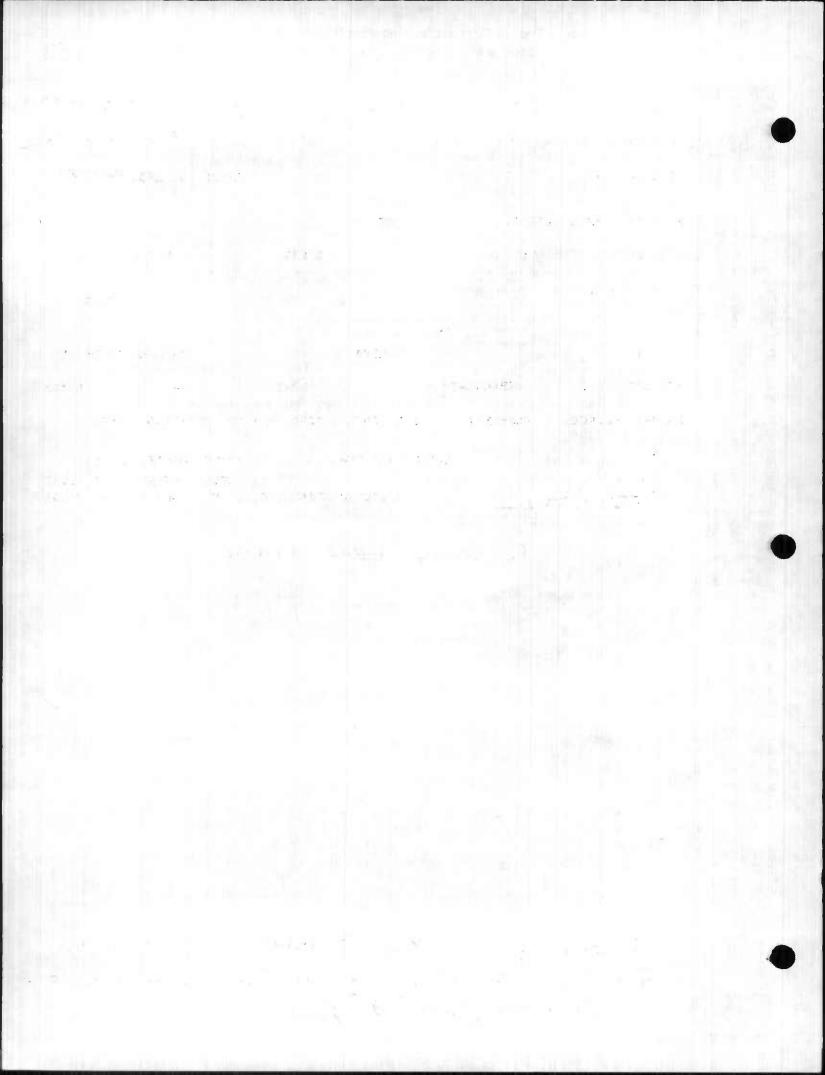
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State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 2. Date of Death 1. Decedent's Name /First, Middle | Last 3. Time of Death Month **Physician** 10.50 Pm MARY July AGNES GEORGE /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GLEN BURNIE THE ARUNDE MORTH ARUNISEL HOCPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 T F Yrs. 63 APRIL 15, 1936 MARYLAND Director 213-34-1275 Usual Residence of Decedent with the Meryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Meryleith and Mental Hygiene.
7 le marked other than "netural", or itema 23a or 28a-f ahov treumatic event, the Medical Exercited must be notified at 1 ☐ Yes 2 ☐ No Director MARYLAND ANNE ARUNDEL ARNOLD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 202 RUSHLEY ROAD 21012 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Maritel Status Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2√2 No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CASHIER GROCERY INDUSTRY when the pages 1 and 2 should be filed. Department of Health and Mental Hydroportant: if them 27 is marking or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM KIRSCHBAUM L. MARY ANN HAYES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BERNARD GEORGE (HUSBAND) 202 RUSHLEY ROAD, ARNOLD, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurlal 2 Cremetion 3 Removal from State LOUDON PARK CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 7/10/99 BALTIMORE, MD. 22. Name end Address of Facility SINGLETON FUNERAL HOME, P.A., 21. Signifyre of Fundral Service Licensee 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 trasan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** HEART PALLIRE /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician end s the burial-transit The law requires that the death certificets be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or es a consequence of): ed by the detached 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the 1 Yes 2 No 3 Probably 4 Onknown Division of Vital Records. ģ 24b. Were autopsy findings evailable prior to should t 24a. Wes en autopsy performed? Completed completion of cause of death? s certificate hes b director, page 2 s 1 Yes 20 No 1 Yes 2 100 or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Depatient Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending within 24 hours efter death.

To the Funeral Director: All completely filled in by the fu death. Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier t 🗹 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. edicai 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and alle of certifier MUD 30. Name and audress of person who completed cause of death (Item 23a) (Type, Print) PRIVE GLEN BURNIE HOSPITAL MABAT 501 1999 Registra/s Signature Registrar

DHMH 16 Rev 6/95



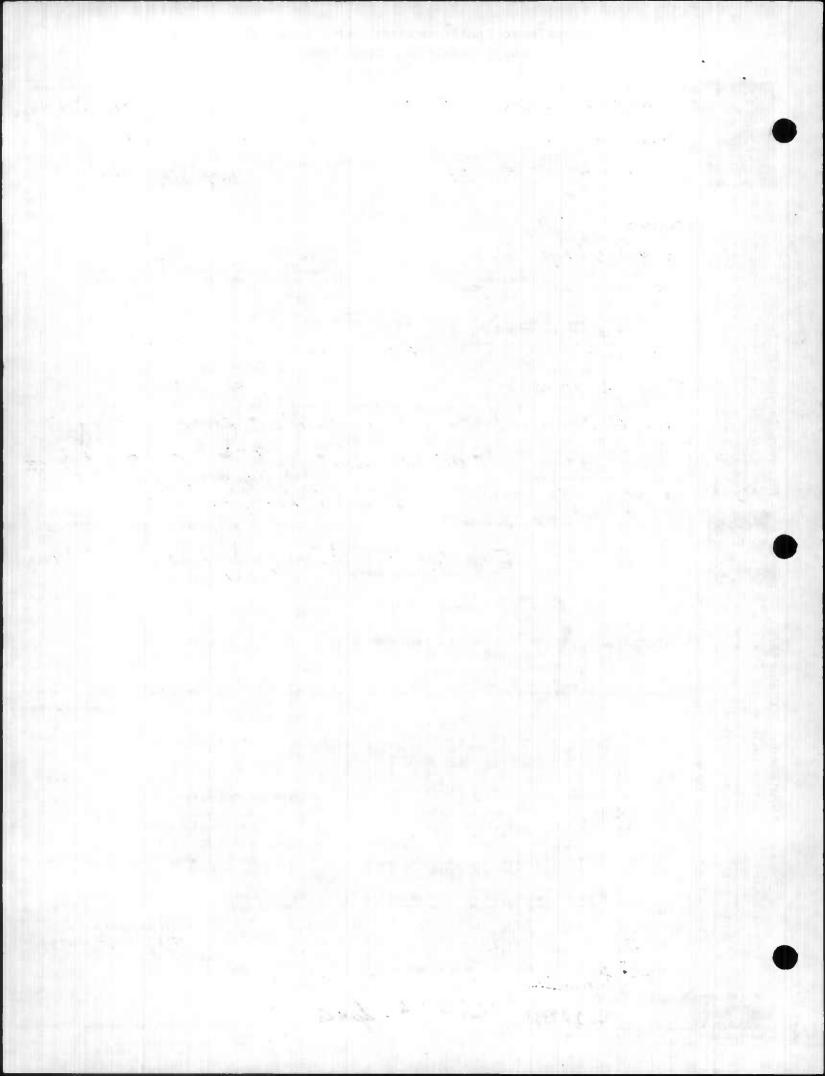
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death 2. Data of Death **Physician** HERBERT KAREN ElizABETH 4b. City, Town, or Location of Death 1999 05 /Medical 4a Facility Nama (If not institution, giva street and number) 4c. County of Death **Examiner** Baltimore NIA Hospital If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F Months AUG. 11, 1964 Mary 216-84-9408 Yrs. 34 Director Usual Rasidence of Decedant 10b. County 10a, Stata 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f shot traumstic event, the Madical Examinar must be notified as BOITHRUE JETTES 2 No Directo Carylow 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 72 hours after deeth with HAGE 3730 21215 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 No 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. Nevar Married 2 Married 1 Yas 2 No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Own Home Elemantary/Secondary (0-12) College (1-4or 5+) HOME MAKEN 8# grade 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middle, Last) Be Pages 1 and 2 should be in nant of Haalth and Mental I Mary E. Rogers Robert L. HEVBERF 19b. Meiling Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Mary E. ChAMBERS of Haalth a Mountmor Court BALHHORE, HADAIT MITHEN Baltimore, 20b. Placa of Disposition (Name of camatary, crematory or other p 20c. Location - City or Town, Stata 20a. Mathod of Disposition Burial 2 Cramation 3 Ramovai from Stata Department of Important: If any injury or = 0 4 ☐ Donetion 5 ☐ Othar (Specify) Lion CENERA Address of Facility CHATMAN-KEISTERS HOWN KO 21. Signature of Funeral Service Liogna 22. Nama and Address of Facility BAMMORE Kons 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. 221 **Physician** tage Acquired Immone Deficiency to (or as a consequence of): Syndrome /Medical Immediata Causa (Finai ~ 10 years disaasa or condition rasulting in daath) Examiner Examiner physician and the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiate causa. Enter Underlying Causa (Disease or Injury that initioted avants resulting in death) Last Dua to (or as a consaquanca of): P.O. Box 68760 Physician/Medical Dua to (or as a consequence of): attending pl signed by the aid Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy pega 2 1 Yas 2 No 1 Yas 2 No Division of Vital Hospital or Attending Physician: 24 hours after deeth. Funeral Director: After this cartifice 25. Was casa rafarred to medical axaminar?
1 ☐ Yas 2 区 No funeral director. 28. Place of Daath (Chack only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Inpatient 2□ER/Outpatient 3□ DOA 27. Mannar of Death 28a. Deta of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation 1 🗷 Natural 1 Yas 2 No 2 Accident 3 Suicida 6 Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledga, death occurred at tha time, data and place, end due to the causa(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. edical To the Hospi within 24 hou To the Funer completaly fil 29a, Certifier 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 05 1999 They Manafi: 30. Nama and addrass of person who completed causa of death (itam 23a) (Type, Print) Roy Hanaki 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State JUL 121999

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 2. Dete of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) Month De eword Horse Juli 946 150 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (if not institution, give street and number) Randellton North west Hospa if Under 24 Hrs. If Under 1 Yeer 6 Sax 7. Age (In yrs. last birthday) 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Days 1X M 2□ F Months Hours Min. Yrs. 73 M.D. 217-20-7822 Usual Residence of Decedent ი 5 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits XYes 2□ No MD NA Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 14. Race - American Indien, 21207 3642 Forest Hill Road 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Self Employed 3rd grade na 18. Mother's Name (First, Middle, Maiden Sumeme) Unknown 17. Father's Name (First, Middle, Last) Howard Hursey 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 21207 3642 Forest Hill Road. Baltimore Md Mary Jackson-Friend 20b. Place of Disposition (Name of cemetery, cremetory or other piece) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurlal 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/13/99 Randallstown, King Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each tine. Approximete Intervat Between Onset end Death tmmediate Cause (Finet ASCAD disease or condition resulting in death) Due to (or as e consequence of): Cordov Pulmona Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in death) Last Due to (or as e consequence of): Due to (or es e consequence of): 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 Yes 2 No 3 Probably 4€ Unknown 24b. Wera autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yes ANO 1 □ Yes 2 □ No. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient GE DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury et Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, and due to the cause(s) and menner as stated. (Check only one) 2 Madical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and manner stated.

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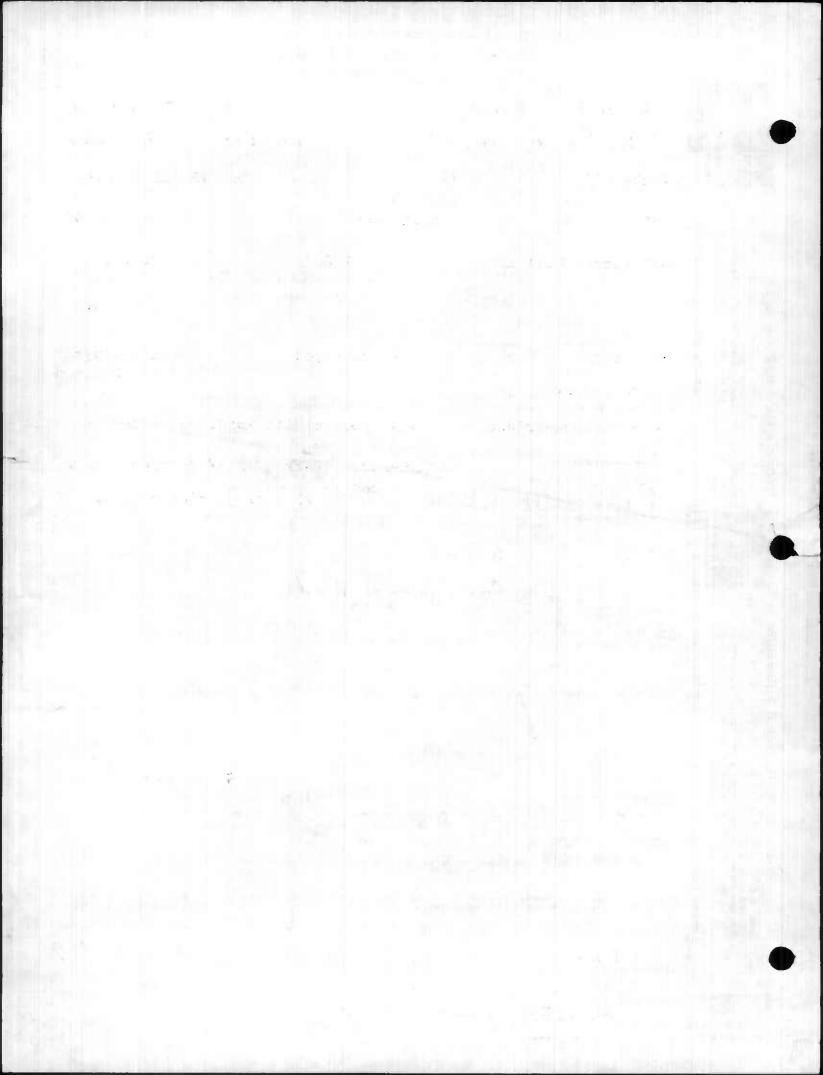
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Hospital Cenier DUTTAWENT Spork

29c. License number

29d. Date signed (Month, Dev. Year)

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Piease Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** ELIZABETH HELINSKI 6:30 PM 1999 VERONICA Jal /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not Institution, give street and number) Rosedale

If Under 24 Hrs.

Winter | Min. (Month, Day, Year)

Oct. 19, 1912 4c. County of Deeth Examiner SEUARE Ceulek day) If Under 1 Yeer BATTIMORE FRANKII M 5. Societ Security Number HOSPILAL 9. Birtholece (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Months Deys MARY L'AND 218-07-3358 Director 86 Usuel Rasidenca of Decedent the Marylend 10a Stete 10c. City, Town or Location r 28a-f show 10b. County 10d. Inside City Limits XYes 2 □ No Director BALTIMORE MD. N/A 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? ma 23a or U.S.A. 241 S. CASTLE STREET Funeral 21231 12. Wes Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ② Who If Yes, Give Yeer or Dates: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 7 is marked other than "natural", or items traumatic event, the Modical Examples or man 14. Rece - American Indien, 11. Maritel Status Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: by 3 XWidowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than WESTERN ELECTRIC PLANT SUPERVISOR 17. Fathar's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be JOHN HELINSKI ROSALIE BLACHOVICH 19a. Informent's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) BERNARD E. HELINSKI/SON 22 GLENMORE AVENUE, BALTIMORE, MD. 21206 20b. Pleca of Disposition (Name of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete Department of Important: If It any Injury or o 1 Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donation 5 ☐ Othar (Specify) STANISLAUS CEMETERY 7/14/99 | BALTIMORE, MD. 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only ona cause on each lina. Approximete Interval Between Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting In death) /Medical · CARdiAc DysRhy **Examiner** Examiner YOCARDIAL FIFARC physician and the burial-transit Sequentielly list conditions, if any, taading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated evants resulting to deeth) Lest Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Anem LA Physician/Medical Due to (or es e consequence of): d for use as t Pert II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobecco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Preumonia 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24e. Was en eutopsy performed? page 2 s 2 No Hospital or Attending Physician: 25. Was casa referred to medical exeminar? 26. Piece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 27. Mannar of Death 28c. Injury et Work? 28d. Describe how injury occurred 28a. Deta of injury (Month, Day Year) 28b. Time of Natural 5 Pending 1 TYes 2 □ No investigation 2 Accident aftar deat 6 Could not be determined 3 Sulcide 28e. Pleca of tnjury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Streat end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and menner as stated.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Direct Month 4:45-M **Physician** 07,199 MARGARET ELIZABETH JOHNSON JULY · /Medical 4b. City, Town, or Location of Peath 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner BALTIMORE CATON MANOR GENESIS Hours Min. 8. Date of Birth (Month, Dey, Year) FEB 7 194 If Under 1 Yee 5. Social Security Number Birthplace (State or Foreign Country)
 NORTH CAROLINA 7. Age (In yrs. last birthdey) **Funeral** Days 1 M 2 XX Months Yrs 57 212-40-0034 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health end Mental hygiena. nnt: if Item 27 is marked other than "natural", or Nema 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE CITY Directo MARYLAND N/A 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? tem 27 is marked other than "natural", or itema 23a or other traumatic event, the Medical Examples must be a 21229 U.S.A. 908 KEVIN ROAD Funerai Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Maritei Status Black, White, etc. 1 Yes 2XXIo If Yes, Give Year or Detes: 1 Never Married 2 Married 1 Yes 2X No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent'a Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LUTHERAN HOSPITAL NURSES ASSISTANT 10th grade 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) MARGARET STALEY CECIL GOINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Samuel Johnson/Husband 980 Kevin Road, Baltimore, Maryland 21229 Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition permit. Pages Department of Important: If It any Injury or o Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 7-10 BALTIMORE, MARYLAND 22. Name and Address of Fecility 21. Signature of Funeral Service Ligensee WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Dwalin /Medical Immediate Cause (Final disease or condition resulting in death) Examiner physician end s the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or as a consequence of) 88 980 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown serten scor signed t þ 24b. Wera autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of deeth? s certificate has b director, pege 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medicel examiner? 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 24 hours after dea Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier edical compietely (Check only one) within 2 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture and title of certifier A D21684 tymae Mo Altenday Doctor

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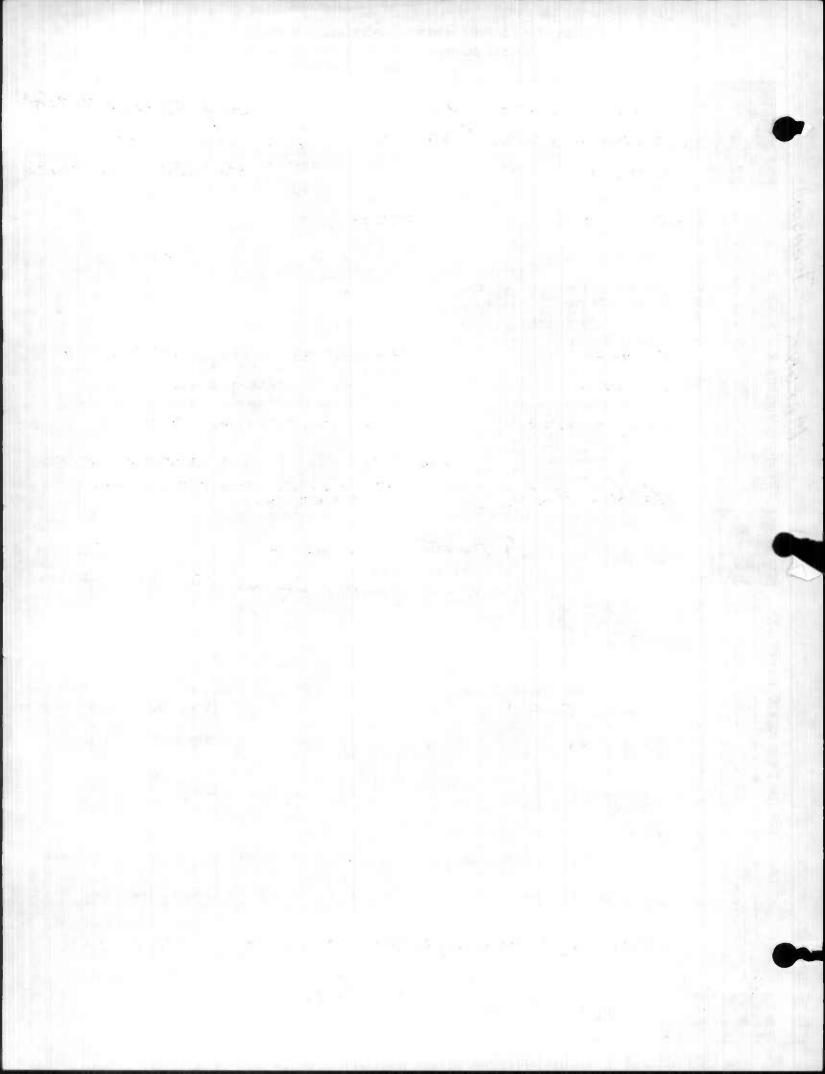
30, Name and address of person who completed ceuse of death (Item 23a) (Type, Print) C · V · C TRIAC · M · O , \$ 109 R is C H CR

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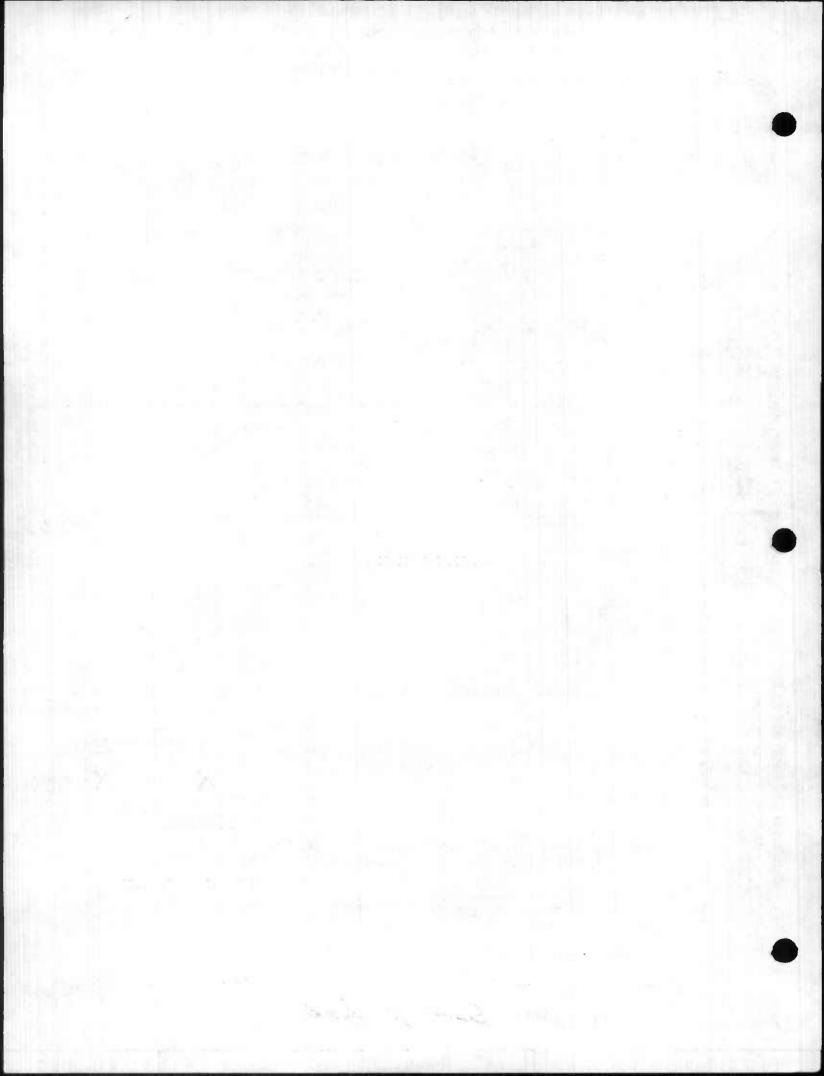
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State of Maryland / Department of Health and Mental Hygiene Nathaniel Johnson Certificate of Death Reg. No. AMEND ITEM#23a, 27, 28a-f PER MED, G773 7-22-99 i.a. 1. Decedent'a Name (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month Year **Physician** July 04, 1999 NATHANIEL JOHNSON 12:20 P.M. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1516 Bethel Street Baltimore If Under 1 Ye If Under 24 Hrs. 6. Date of Birth (Month, Day, Year) OCT 12 19 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 125 M 2□ F 39 Yrs MARYLAND 216-84-3534 Director 1959 Usual Rasidence of Decedent the Maryland 10a Steta 10b. County 10c. City. Town or Location 10d Inside City Limits ahow XX Yas 2 No Director BALTIMORE CITY 288-1 MARYLAND N/A 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 23a 1738 NORMAL AVENUE 21213 U.S.A. Funeral Waa Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 12. Was Decedent Evar in U.S. Black, White, atc. 72 hours after 1 ☐ Yes 2 ZANO 1 Devar Married 2 Married altimore, Maryland 21215-0020 b 1 ☐ Yes 2 ☒ No Specify: Specify: BLACK à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) 10th grade LABORER CONSTRUCTION 17. Fathar's Nama (First, Middla, Last) 18 Mother's Nama (First Middle Maiden Sumema) Be Pages 1 and 2 should be nent of Health and Mental JOSEPH CLARK JOHNSON JERELINE JOLLY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . rtant: If Item 27 I Jereline McLaurin/Mother 1738 Normal Avenue, Baltimore, Maryland 21213 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) WESTERN STAR 7-12-99 BALTIMORE, MARYLAND 21. Signature of Funaral Service Licental 22. Nama and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. Approximete Intervel Between Onsat and Death **Physician** /Medical Immediata Cause (Final diseasa or condition rasulting in death) NARCOTIC INTOXICATION Examine Due to (or es a consequence of): Examiner be axecuted Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or Injury that initiated eventa rasulting in death) Last Dua to (or as a consequence of): physician s the burial Box 68760, Physician/Medical The law requires that the death certificate Due to (or as a consequence of) 88 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? has page 2 certificate of Vital Hospital or Attending Physician: director. Be 25. Was case rafarred to medical axaminar? 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Nother (Specify) at SCENE No Yas 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Mannar of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After Division 1 Netural 5 Pending investigation Injury s after death. 1 Yes 2 No UNKNOWN 2 Accident 7-4-99 UNKNOWN 6 Could not be datarmined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, factory, office building, atc. (Specify) 5 4 Homicide HOUSE 24 hours 1516 BETHEL ST. BALTIMORE, MD edicai 29a. Certified 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner es stated. (Check one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mennar stated. within 2 To the \$ 29b. Signyilum ž and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 0 O.C.M.E. July 05, 1999 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) ARON WHE, MP 111 Penn Street, Baltimore, Maryland 21201 31. Data filed (Month, Day, Year) 32. Registrar's Signetura State

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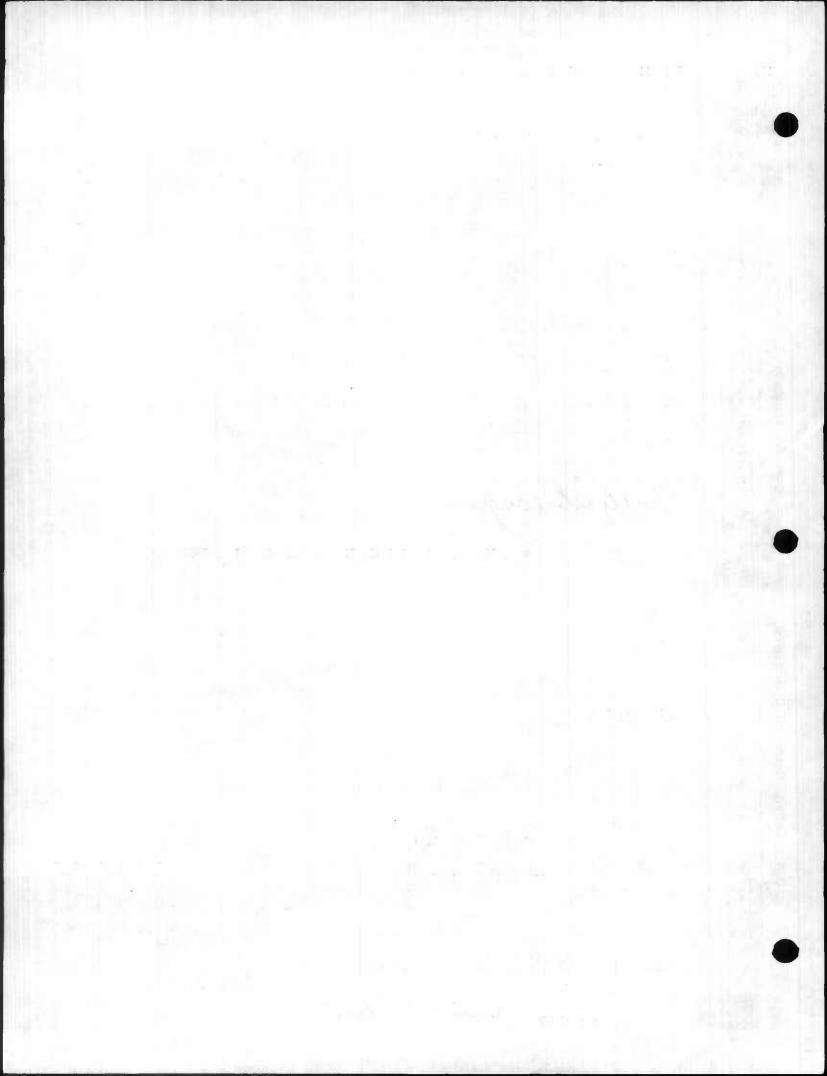


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State of Maryland / Department of Health and Mental Hygiene QQ 21760

ITEMS: #23 PA	ART I, II, 27, 29A-F PE	at)		rtificate	of	Death		2. Dete of De Month	Day	Year	Time of Deeth
/Medical Examiner	RANDOLPH 4a Facility Name (If not institution, give	street and number)	IES	-	- (•		JULY cation of Death		of Deeth	
Funeral Director	215 /0 1000		in <i>yrs. last birthday,</i> 41 Yrs.		Year Days	BALT'I	24 Hrs. Min.	8. Date of Bir (Month, Da		9. Birthplace Country)	(State or Foreign
anyland ahow sdat	Usuat Residence of Decedent 10a. Stete 10b. County MARYLAND N/A	10	Oc. City, Town or L	ocation BALTIM	OP.	P.					nside City Limits
with the Ma or 28=4 be notified	10e. Street and Number 3539 PELHAM AV	ENUE		10f. Zip C	ode	213			10g. Citizen of V U.S	What Counfry?	n
72 hours after death with the Maryland natural", or items 23a or 25a-f ahow final Exercises must be notified at steed by Funeral Director	11. Merital Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:	or in U,S. 13.	Wes Deceder If Yes, specify			gin? (Spe , Puerto F	cify Yes or No Rican, etc.)		ce - American Inck, White, etc.	MERICA
	15. Decedent's Ed (Specify only highest grad	ucetion de <i>completed)</i>	16a. Dece (Give	dent's Usual (kind of work DO NOT use	Occup done retired	eation duning most	of working	ng	16b. Kind of B	usiness/Industr	Y
	Elementary/Secondary (0-12) 12TH 17. Father's Neme (First, Middle, Last)	College (1-4or 5+) N/A		ER'S		ELPE	R		BAKE Meiden Sumen		
New Mer		ONES , SR.		ing Addrage /	Straat	FL(ORIN	E RIC			(a)
nd 2 alth ar 27 la r trau	FLORINE MILLER	MOTHER	3539	Pelh	am			Balto	., Md.	21213	
pemit. Pages 1 a Department of Hei mportant: if item iny injury or othe ance.	20a. Method of Disposition 1 Purial 2 Cremation 3 4 Donation 5 Other (Specify	Removel from Sfefe	20b. Place of Dispo cemetery, cre BALTIMO	metory or other	er pled		JUL	Y 13,		BALTO,	
Medical Examiner edical Examiner	23a. Part1. Enter the disease, or compshock, or heart feilure. List only of Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	NARCOTIC &		TOXICAT	of dyir	ng, such es	cardiac o	r respiretory a		App	2 2 2 1 roximate roxi
ng phys as the	resulting in death) Last	d	e to (or as a consec								
at the d by the etache	Part II. Other significant conditions co SCHIZOPHRENIA	ntributing to death but n	ot resulting in the u	inderlying cau	se giv	en in Part I.					cause of death?
has been be 2 shoul							_	perfo	an autopsy prmed?	available comple of deat	
certific irector	25. Was case referred to medical examiner?	Hospital:	a∏500		Oth	er.		(Check only	one)		8 2□ No
5 85 F	27. Manner of Death 1 Neturat 5 Pending 2 Accident investigation	28a. Date of Injury Found, Day Yo			, Injur		2		dence 6 □Oth how injury occur		
To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined		- At home, farm, st Specify) NOF HOUSE	reet, fectory, o	office			8f. Location (City or To	Street and Number, State) 353	PELHAM	AVE.
ne Hospitu n 24 hours ne Funeral pletely fille	29a. Cartifier 1☐ Certifying Phy (Check only one) Medical Exam	reician: To the best of m liner: On the basis of ex and manner steted	aminetion and/or In	h occurred at vestigation, in	the tir	ne, dete and plnion, deal	d plece, a	nd due to the	cause(s) end me	anner as stated and due to the	cause(s)
To the complex	29b. Signature and title of certifier	tamer		29c. l		e number C.M.E			29d. Dete signe JULY 9	ed (Month, Dey, 1999	Year)
	30. Name and address of person who c	ompleted cause of death			t,	Balti	more,	, Mary	land 212	201	
State Registrar	31. Date filed Mooth Day, Year) (32. Høgistrar's		for	Ka	1					

DHMH 16 Rev 6/95



Please Type or Print in Black Indeible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death AMENDIITEM: #19A PER F.H. G773 7-12-99 WR. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Knox Burl 4b. City, Town, or Location of Death 05 1999 6:00am /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 1332 Stockton Street
Social Security Number 6. Sex 7. Age (In yrs. last birthday)

7. Age (In yrs. last birthday)

7. Age (In yrs. last birthday) Baltimore
| If Under 24 Hrs. | 8. If Under 1 Year 9. Birthplace (State or Foreign Country)
S • C • 8. Date of Birth (Month, Day, Year) 11 24 37 **Funeral** 213-34-7722 61 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits ahow I 1 Yas 2 No Baltimore Directo MD NA 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 238 21217 U.S.A. 1332 Stockton Street Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Status hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married X Married altimore, Maryland 21215-0020 8 1 ☐ Yes 2 ☐ No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) 4th grade na
17. Father's Name (First, Middle, Last) Unknown Laborer Park Division 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H tant; if Nem 27 is marked off lury or other traumatic even Be To Rosalee Knox 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KNOX Sylvia Know-Wife
20a. Method of Disposition 1332 Stockton Street, Baltimore Md 21217 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) King Memorial Park 7/12/99 Randallstown, Md 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee March F/H West I adup Warren 4300 Wabash Ave, Baltimore Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Causa (Final . CARDIAC Arrythmia MINUR disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner Discose years COLONNA ATEU The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Prostake (mariona þ 24a. Wes an autopsy performed? 24b. Were autopsy tindings available prior to Completed END STOY Renal Discon completion of cause of death? page 2 s OBERTATIVE PALMONNY Chonic Discort 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vitai or Attending Physician: funeral director, Be 25. Was case reterred to medical axaminer? 26. Place of Deeth (Check only one) Hospitel: 1 Inpetient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Megner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending n 24 hours after death.

The Funeral Director: After the funeral in by the funeral control of the funeral in th 1 Yas 2 No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical 29e. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the ş 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 03, 1999 D34334 JUL

State Registrar 31. Date filed (Month, Day, Year) **JUL** 121999

ROBERT C. Granwell

32. Registrar's Signature

Ir. MA

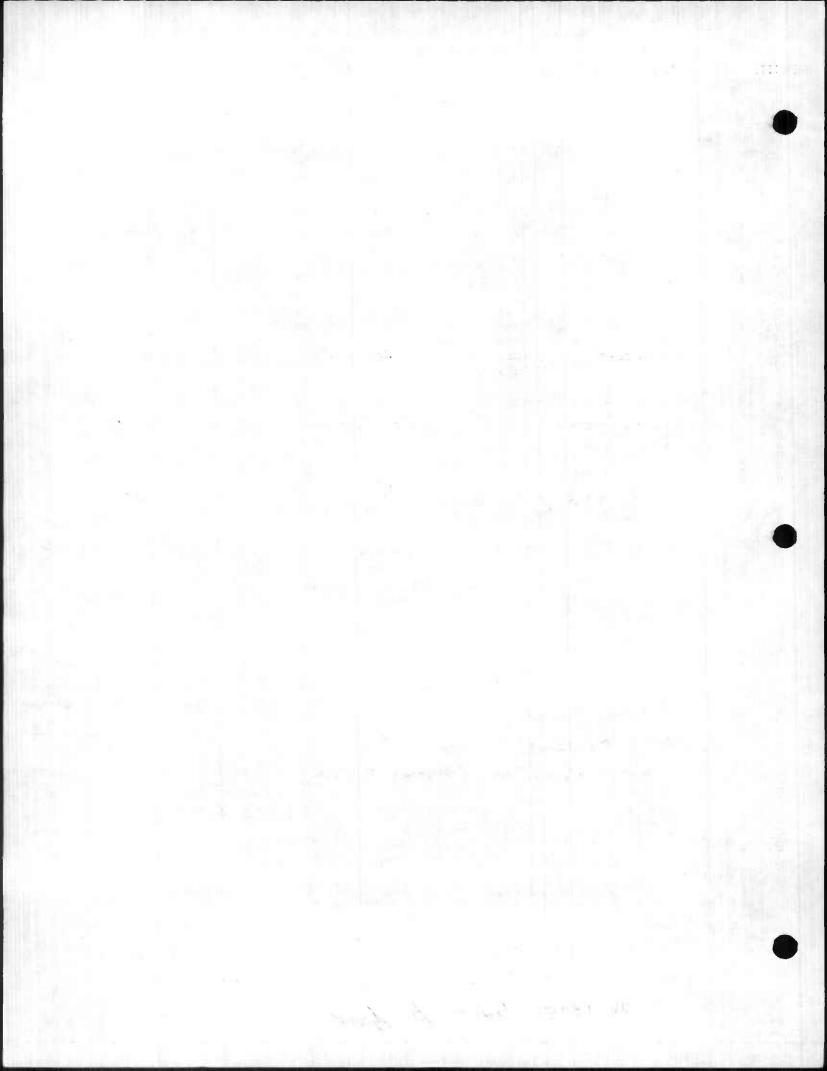
30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

B. Sparky

315 N. CALVERT ST.

Baltimore, my

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Beg. No. 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month Dev **Physician** July 9, 1999 5:30 p.m. Irvin Arthur Long /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 1642 Riverwood Road Essex Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthpiece (State or Foreign Country) **Funeral** Months Days HOKM 20 F 213-38-9756 30, Director 56 Nov. 1942 Maryland Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Essex 1 ☐ Yes 2 No Director 28a-f 156 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 1642 Riverwood Road 21221 U.S.A. 238 Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1 Never Merried 2 X Merried Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 20tho Specify: Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. other then "n Elementary/Secondery (0-12) College (1-4or 5+) 8 Factory Worker Automotive Assembly 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental He last; if them 27 is marked oth lary or other traumatic even Lyona Sigafoos Irvin David Long 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 1642 Riverwood Road, Baltimore, Maryland 21221 Department of Heath a Important: If Item 27 Is any injury or other tra Susan C. Long (wife) 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removel from Stete
4 □ Donation 5 □ Other (Specify) 7/13/99 Baltimore, Maryland Oak Lawn Cemetery 22. Name end Address of Facility
Bruzdzinski Funeral Home, P.A. ature of Paramet Service License Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest,

Approximete

Approximete Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final Myocardia diseese or condition resulting in death) Examiner Examine abuse bacco physician and the burial-transit that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): bue to (or es a consequence of): Physician/Medical cholesterolemia for use r 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wera autopsy tindings available prior to should should 24a. Wes an autopsy performed? Completed completion of cause of death? The 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) To Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home STResidence 6 Other (Specify) 1 Yes 20 No Certification: 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attending 5 Panding investigation t ☐ Yes 2 ☐ No death. 2 ☐ Accident 24 hours after deal Funeral Director: 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospital **Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and mannar as stated.

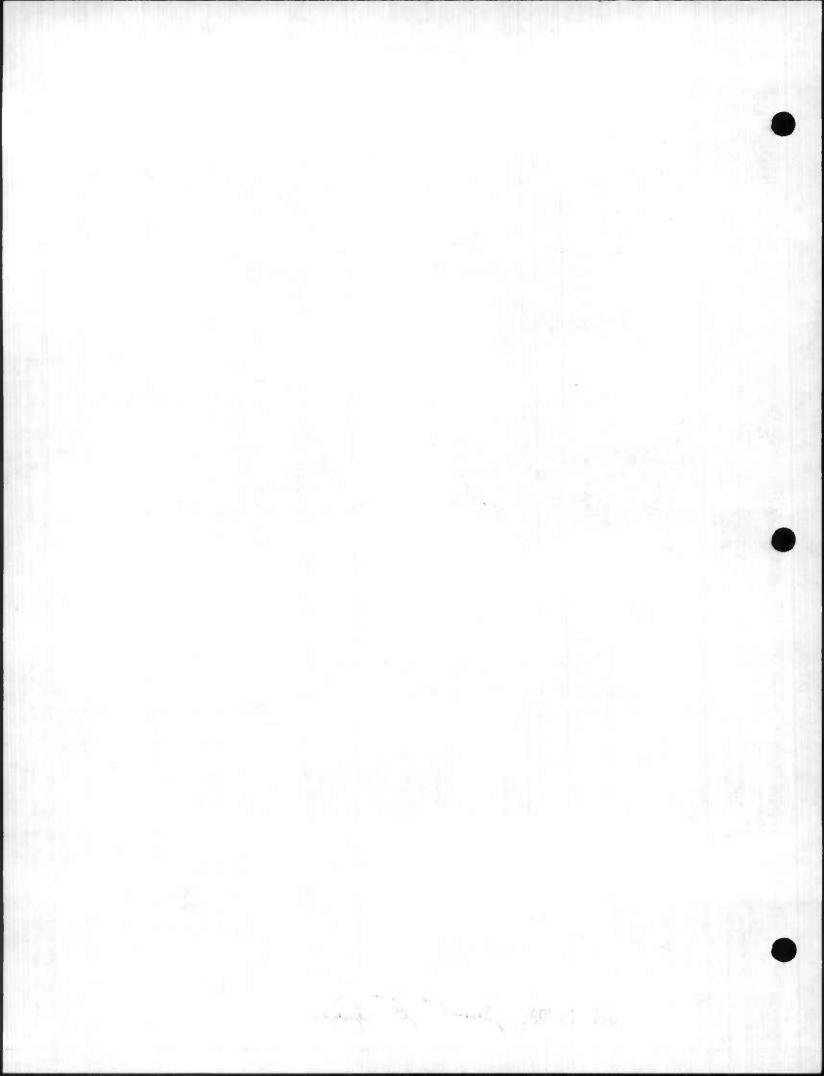
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. 29e. Certifier edical (Check only one) within 2 \$ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 44260 30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print) merritt Blud. Suite 14 Baltimore, "D Kinzinger, md 1576

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Dey, Year)

32. Registrar's Signatu



The law requires that the death certificate be axecuted attending physician and for use as the burial-trans Box 68760. use as t 2 Division of Vital Records, certificate Physician: this funeral After or Attanding within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu Hospital

Physician

/Medical

Examiner

Funeral

Director

in than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death \(\text{Department of Health and Mental Hygiene.} \)
Important: If them 27 Is marked other than "natural", or theme 23s any Injury or other traumatic evant, it was a man injury or other traumatic evant, it

Physician

/Medical Examiner

altimore, Maryland 21215-0020

Directo

Funeral

by

Completed

7

with the Maryland

Physician/Medical Examiner Completed by Peripheral Vascular Disease States 25. Was case referred to medical examiner? Be 2 1 Yes 2PNo 27. Manner of Death Certification: 1- Naturel 2 Accident 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a, Certifier edical (Check only one)

29b. Signeture end/title of certifier

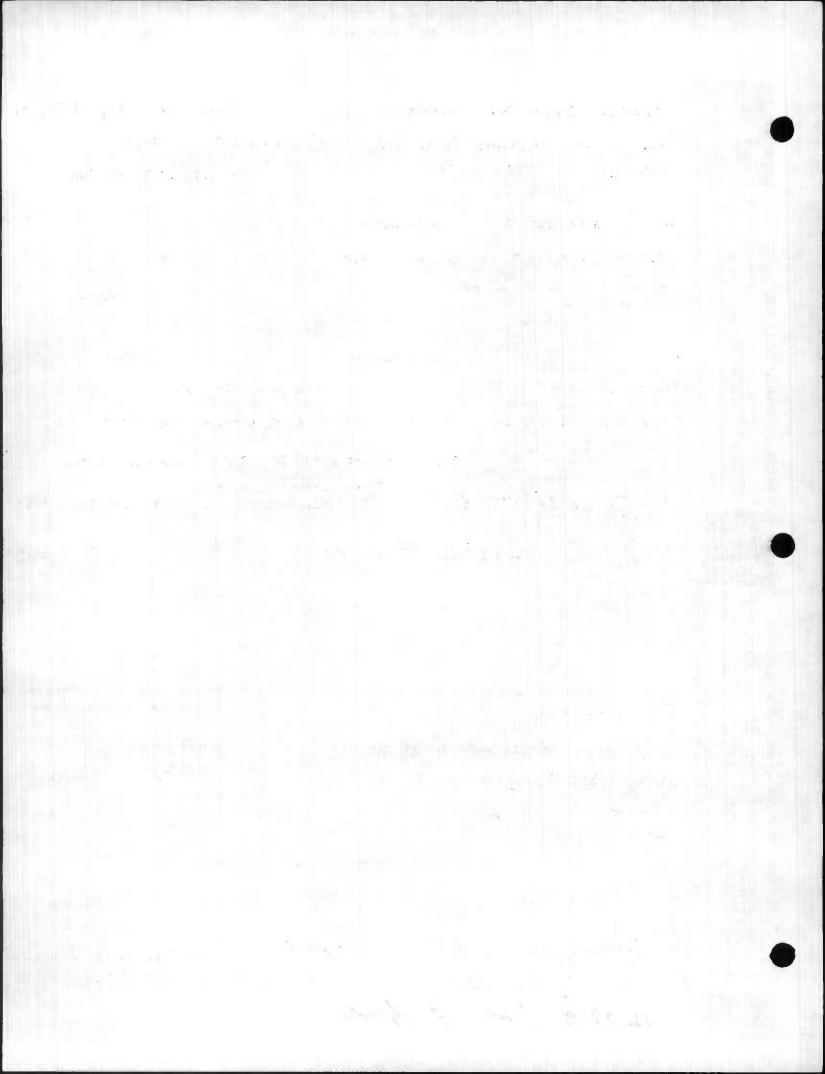
29c. License number 152183 29d. Date signed (Month, Day, Year)

as of person who completed ceuse of death (Item 23e) (Type, Print)

Street, Baltinors, MD. 21287 600 N. Wolfe 31. Date fited (Month, Day, Yell)

State Registrar

32. Registrar's Signature



Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiens.
Important: If Item 27 is marked other than "natures", or hems 23s or 28s-f show any injury or other traumatic event, the Medical Examines must be notified at

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

			Cei	titicate of	f Death		Reg. No.	3 6	104
1. Decedent's Name (First, Middle, Last,)					2. Date of Dec	ath Day	Vone	3. Time of Death
EMMA LEE LOYAI						JÜLY	06 ^{Day}	1999gar	5;40 A
4a Facility Name (If not institution, give	street and number	er)			4b. City, Town, o	r Location of Death		nty of Death	
2110 DRUID HI	LL AVE				BALTIM	ORE	N/A		
5. Social Security Number 6. Se.	х Эм Х О F	Age (In yrs. I	The second second	If Under 1 Yea Months Day			h y, Year)	9. Birth	place (State or Fore
213-26-8222	J.M. 42CJ F		68 Yrs.			12 28	1930	South	h Carolin
Usuel Residence of Decedent 10a. State 10b. County		10c, City	, Town or Lo	cation			-		10d. Inside City Lim
Md. N/A		D.	7	0'1					1 Yes 2 1
10e. Street and Number		Ba	TETHOL	e City			10g. Citizen o	of What Cou	intry?
2110 Druid Hill Av	renue	Apt.	2	2121			U.S.		
11. Marital Status	12. Was Decede	-				(Specify Yes or No		Race - Ameri	ican Indian,
1 Never Merried 2 Merried	Armed Force					(Specify Yes or No orto Rican, etc.)		Bleck, White	
3 ₩ Widowed 4 Divorced	If Yes, Give Year or Date:	s:		1 ☐ Yes 2)X N	o Specity:		Spec	city: Bla	ack
15. Decedent's Edu			16a. Deced	lent's Usual Occ	upation e during most of w	nd in	16b. Kind of	Business/Ir	ndustry
(Specify only highest grad Elementary/Secondary (0-12)	College (1-4c	or 5+)	life. L	OO NOT use reti	red)	Orking			
8th			Hous	ewife			Pri	vate	
17. Father's Name (First, Middle, Last)						ame (First, Middle,	Maiden Sum	name)	
James Williams					Emma Hu				
19e. Informent's Name/Relationship (Ty						Rural Route Numbe			ip Code)
Darnell Brown/Daug	hter	20h Bi	457 M	anns Ct	. Baltimo	Date Date			Chata
20a. Method of Disposition ↑ Burial 2 Cremation 3 □ F		te CE	emetery, cren	natory or other p			20c. Locatio		
4 Donation 5 Other (Specify) 21. Signature Funds Service License		Mt		. Cemete: . Name and Add		7/12/99	Lands	downe	, Md.
Pert1. Enter the disease, or complete shock, or heart failure. List only or	cations that caus ne course on each	sed the death n line.	1	206 W. I	H. Powell North Ave ying, such as cardi	enue, Bal	timore	ces, Md.	21217 Approximate Interval Between Onset and Death
23s Pert1. Enter the disease, or consistence, or heart failure. List only or translate Cause (Finel disease or condition resulting in death)	(rioscle	n. Do not ente	206 W. I	Worth Ave	enue, Ballac or respiratory en	timore	ces , Md.	Approximate Interval Between
Immediate Cause (Finel disease or condition resulting in death)	(Due to (or	Do not ente	206 W. If an arrange of the mode of the cardiov quence of):	North Ave	enue, Ballac or respiratory en	timore	ces, Md.	Approximate Interval Between
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Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pert II. Other eignificant conditions condi	Arter	Due to (or	n. Do not entered a consequence a consequenc	Cardiov uence of):	vascular	23b. Did	tobacco use Yes 2 No an autopsy rmed? ECTION Yes 2 No	contribute to 3 Pro	Approximate Interval Between Onset and Death Death Onset and D
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tmmediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pert III. Other eignificant conditions conditions conditions conditions. 25. Was case referred to medical examiner? 12 Yes 2 No 27. Manner of Death 12 Netural 5 Pending investigation	Arter Arter Arter Arter Arter Arter	Due to (or Due to (or Due to (or but not resu	n. Do not entered at the consequence of the consequ	cardiov cardiov uence of): uence of): uence of): derlying cause of the second cardiov 28c. Inj	ying, such as cardi vascular given in Part I. 26. Place of D Other: 4 Nursing	23b. Did 23b. Did 24a. Wes perfo INSPI 10 eath (Check only of	tobacco use Yes 2 No an autopsy med? ECTION Yes 2 No Yes 2 No	contribute to 3 Pro	Approximate Interval Between Onset and Death Death Onset and Death Death Onset and Death Death Death Death Death Death Death D
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State Registrar

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year)

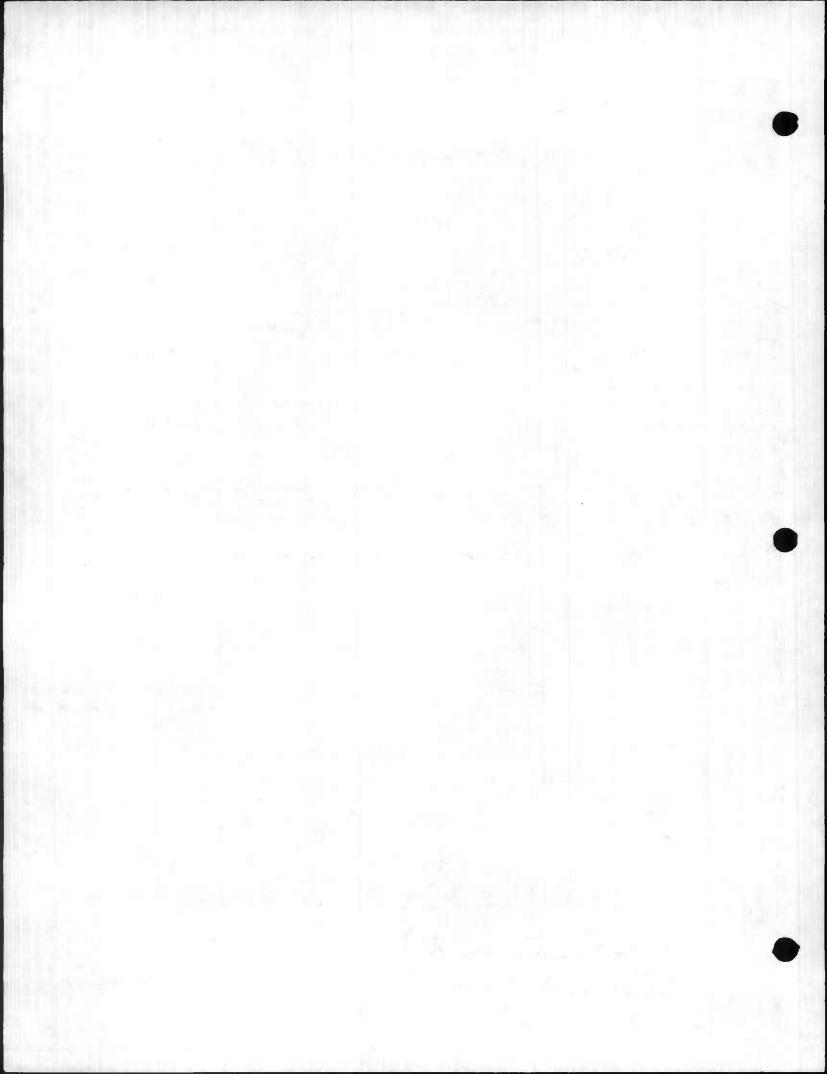
JUL 1 2 1999

22. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

To the Hospital or Attending Physician: within 24 hours after death.

To the Funansi Director: After this certifica completely filled in by the funansi director;

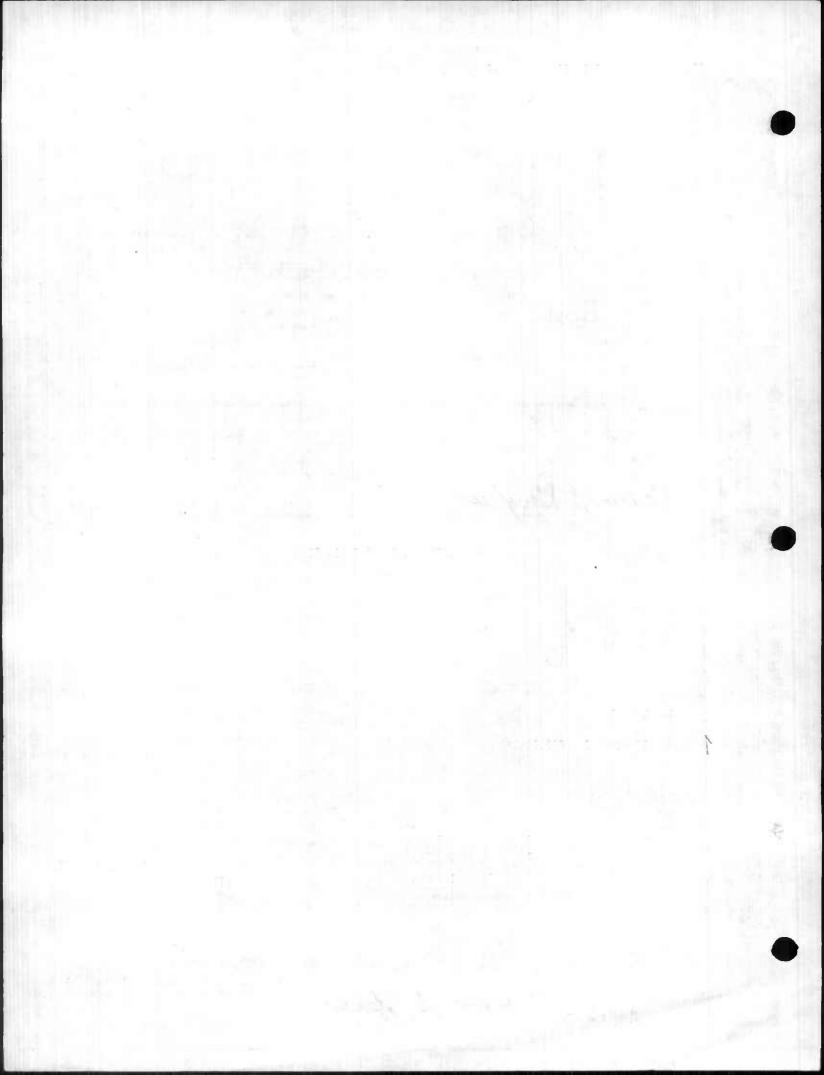


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State of Maryland / Department of Health and Mental Hygiene 99 2 1 7 6 5

ASP	MEND IT	EM: #7, 23 PART I, I		PER MEO G7	Certifica	te of	Death	2. Date of Dec	Reg. No.	3. Time of Death
	ysician	CHERRYN	LOVE					Month JULY	Day	Year 2343
	Medical caminer	4a Facility Name (If not institution,)			4b. City, Town, or	Location of Death		
Fun Dire	neral 2	MERCY HOSPIT 5. Social Security Number 20-64-2419		ge (In yrs. last bi		r 1 Year Days		8. Date of Birt (Month, Day		Birthplace (State or Foreign Country) MARYLAND
P .	-	Usuel Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Location					
e Maryle	Director	MD. N/A			BALTIMO	RE				10d. Inside City Limits 1 1 Yes 2 No
ath with the		712 ST. PA	UL		10f. Zi	212	202		U.S.A.	hat Country?
5-0020 72 hours after death with the Manyland natural, or frame 23a or 28a-f show	by	11. Merital Stetus 1 Never Merried 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Detes:	No	13. Was Dece If Yes, spo	cify Cul	Hispanic Origin? (S ban, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	Black	- American Indian, , White, etc. AFRO-AMERICA
21215-0020 od within 72 hours afl giene.	r, the Medical	15. Decedent' (Specify only highest Elementary/Secondery (0-12)			life. DO NOT	ork done	during most of wor	rking	16b. Kind of Bus	
d 21 Hygien ther th	Con		2 YEA	RS	CLERK					AIDE PHARM
Maryland d 2 should be file th and Mental Hy 7 is marked othe	To Be	17. Father's Name (First, Middle, L WILLIAM BI	•					FORSTEI	Maiden Surname R)
- 200	r traum	19e. Informent's Neme/Reletionsh RONALD BIRD /		196	o. Mailing Addres 33 AMBC	s (Stree	RCLE B	ALTO, I	AD	State, Zip Code) . 220
Baltimore amit. Pages 1: bepartment of He mportant: if Nem	ury or oth	20e. Method of Disposition 10 Buriel 2 Cremetion 4 Donetion 5 Other (Sp		cemete	of Disposition (Na ony, crematory or ZION CE	other pla		Date Y 12,		City or Town, State LTO, MD.
Depart Depart	any in	21. Signature of Funerel Service L	Dauglas	V	CAI	VIN	ess of Facility I B. SCR E. PRES			HOME
Physic /Med Exami	iner	23a. Part1. Enter the disease, or shock, or heert teilure. List of the control of	a	ACUTE C	OCAINE IN consequence of	LOXIC				Interval Between Onset and Death
certificate be assecuted nding physician and		Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in deeth) Last	c		consequence of)					
death cert	for us									†
as that the death cerigned by the attendir	detached for use	Part II. Other algoriticant condition BI-POLAR DISORDER	s contributing to death t	but not resulting i	in the underlying	cause g	iven in Part I.		res 2 No	tribute to the cause of death? 3 Probably 127Unknown
ew requir	2 should pleted	CHRONIC RENAL INSU	FFICIENCY						an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
= F 6	Com							DEL	res 2□No	yes 2□ No
sician: The certificata	Be	25. Was case reterred to medical examiner?	11					ath (Check only o	ne)	
_ 5 0	uneral dir	27. Manner of Death 1 Netural 5 Pending	Hospitel: 1 Inpati		Time of P	28c. Inju	ury at ork?	28d. Describe t	lence 6 Other now injury occurre	
DIVISION OF The Hospital or Attending Physician 24 hours after death. To the Funeral Director: After this	led in by the funera Certification:	2	ot be 28e. Plece of the building, e	111:	erm, street, fecto		Yes 21 No		Street and Nymbern, State) IZ	r or Purel Royle Number. #4
To the Hospital within 24 hours To the Funeral	pletely fille		Physician: To the best kaminer: On the basis of and menner st	of examination an				, and due to the	cause(s) and man	ner as stated.
To th	Me	29b. Signature and title of certifier	. 0	,	29	c. Licen	se number		29d. Date signed	(Month, Day, Year)
		Jenn 30, Name and address of gerson y	is J. Ch	ute no	(Type Print)	0.0	C.M.E		JULY 07	, 1999
		Dennis J-C	hute, no	MAX.	111			Baltimo	re, Mary	rland 21201
Re	State gistrar	31. Dete tiled (Month, Day, Year)		rer's Signature	. spa	Ks				

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 1. Decedent's Nama (First, Middle, Last) ALFRED MILLS 12:20 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MEDICAL CENTER BALTIMORE, MD UNIVERSITY OF MARYLAND BALTIMORE CITY If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Yaar 5. Social Security Number Birthpiece (State or Foreign Country) Deys 10 M 2□ F Months 212-46-8309 5-31-45 N. Carolina Usual Residence of Decedent 10a State 10d. Inside City Limits 10b Counts 10c. City. Town or Location Yas 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 3821 Parkheights Avenue 1st floor 12. Was Decedent Evar in U,S. Armed Forcas? 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Wherried 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Trackman Railroad 12th 17. Father'a Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Eddie Mills Nancy Easter 19a. Informant's Name/Reletionship (Type, Print) 19b. Maiting Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 4019 West Coldspring Lane Baltimore, Maryland 21215 Louise Y. Terry (Sister) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal Irom State 7/15/99 King Memorial Park Randallstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Caple Funeral Service 21. Signature of Funeral Service Licenses Party Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart leiting List only one cause on each line. 5502 Winner Avenue Baltimore, Maryland 21215 Approximete Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) KESPIRATORY One Week Due to (or as a consequence of): Due to (or as e consequence of) PNEUMONIA Four Weeks Due to (or es e consequence of) DEFICIENCY SYNDROME One Year IMMUNE 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 26. Place of Deeth (Check only one)

Physician /Medical Examiner Examine

ettending physician

Pes

After this

To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funera

Physician/Medicai

by

Completed

8

To

Certification:

edicel

Physician

/Medical

Examiner

Directo

à

Be

Funeral

Director

28m-f

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Herne 23a

natural, or

Hygiene.

permit. Pages 1 and 2 should be f Department of Health and Mental

Maryland 21215-0020

Baltimore,

Box 68760.

P.O.

Division of Vital Records.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated appears that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f.

Osteomyelitis

Septic Arthritis

25. Was case referred to medical examiner? 1□ Yes 21 No 27. Manner of Death 1 Natural
2 Accident

5 Pending investigation 6 ☐ Could not be 28a. Dete of Injury (Month, Day Year)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28e. Placa of fnjury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

281. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

3 Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and manner as stated.

| Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end menner stated. 29d. Date signed (Month, Day, Year)

29c. License number

29b. Signature and title of certifier anna

7-10-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

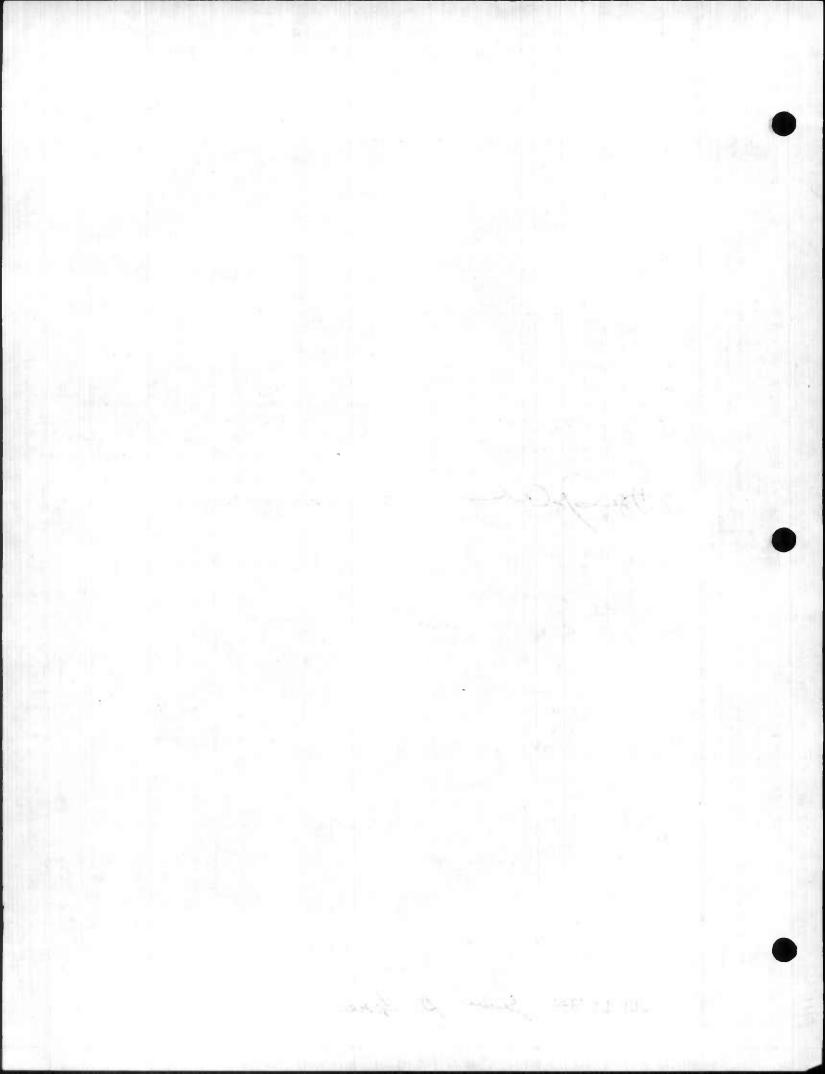
Hospitel:

M. LAMAR BRYANT JR. MD University of Maryland

22 SOUTH GREENE STREET BALTIMORE, MD 21201

82. Registrar's Signetur

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEM: #19A PER F.H. G773 7-12-99 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 0645 ZUL Murphy /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital of Baltimore Baltimore If Under 24 Hrs. If Under 1 Year 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Months Deys Hours 1 M 2 □ F Yrs 09 78 N.C. Director 244-12-3279 11 atient Known as: Gorman Murphy Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow 7 is marked other than "natural", or flems 23a or 28a-f ahov traumetic avent, the Medical Exeminar must be matthed at Was 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4305 Katherland Ave 21207 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-ff Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. Yes WNo 1 ☐ Never Married 2 ☐ Married 1 Yas 2 No Specify: 29 3 Widowed 4 □ Divorced Yaer or Detas: Black Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry marked other than Elementery/Secondery (0-12) College (1-4or 5+) Welder MD Ship Yard 7th grade na 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be filt. Department of Health and Mental Hy Important: If Itam 27 is marked oth any injury or other traumatic avent 8 Carter Murphy Eula Bell Lucas 19e. Informant's Name/Reletionship (Type, Print) ROSE_ 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Rosde L. Brewer-Sister 2433 W. North Ave, Baltimore Md 21216 20a. Method of Disposition 20b. Piece of Disposition (Name of cematery, cremetory or other place) Dete 20c. Location - City or Town, Stete XXBurial 2 Cremation 3 Remove from State 4 ☐ Donation 5 ☐ Othar (Specify) 7/13/99 Dulaney Valley Cem. Towson, 21. Signatura of Funeral Service Li 22. Name end Address of Fecility March F/H West 4300 Wabash Ave, 21215 Baltimore Md 23a. Part1. Enter the disaesa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Finel Acute disaese or condition resulting in deeth) MOU Examiner Due to (or as a consequence of) Examiner AD attending physician and for use as the burial-tran-Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es a consequence of): ed by the a Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detach 1 Yes 2 No 3 Probably Unknown by 24b. Wera autopsy findings available prior to Completed 24a. Was an eutopsy completion of cause of death? 2 No 20 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only ona) 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28h Time of 28c. injury af Work? 28d. Dascribe how injury occurred Certification: After

 Hospital or Attending P
 24 hours after death.
 Funeral Director: After to To the Hospital or A within 24 hours after To the Funeral Dire complataly filled in b

> State Registrar **DHMH 16 Rev 6/95**

31. Data filed (Month, Dey, Year) JUL 1 2 1999

2/sel

29b. Signature and title of certifier

2 Accident

3 Suicide

(Check only one)

29a. Certifier

edical

5 Pending

investigation

30. Nama and address of person who completed causa of death (item 23a) (Type, Print)

6 Could not be determined

32. Registrer's Signeture

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 Tyes 2 No

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end pleca, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

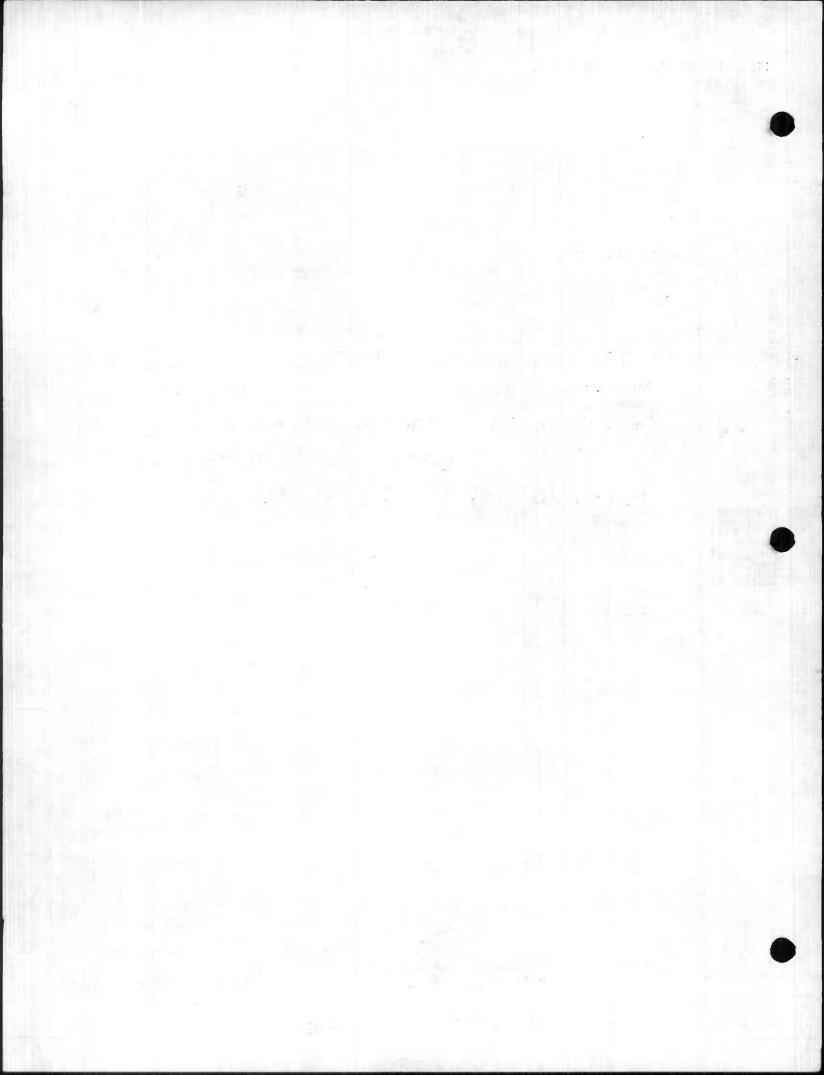
29c. License number

737573

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

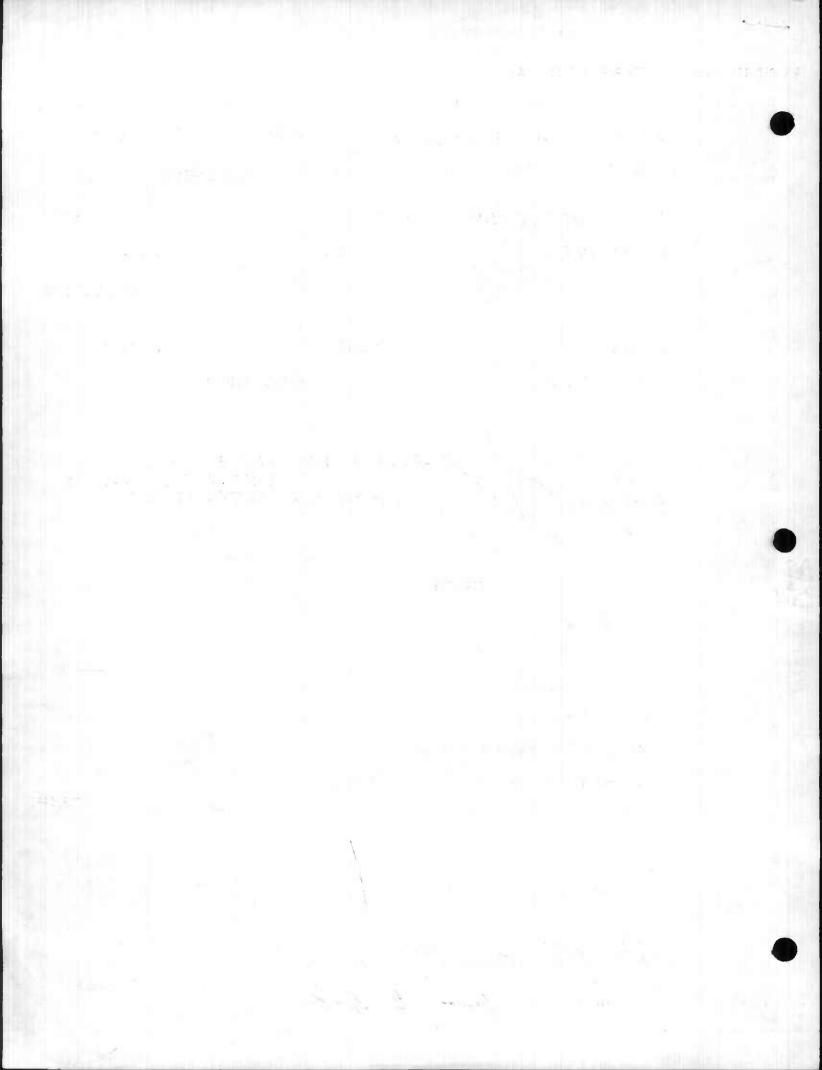
Battle MD

29d. Data signed (Month, Day, Year)



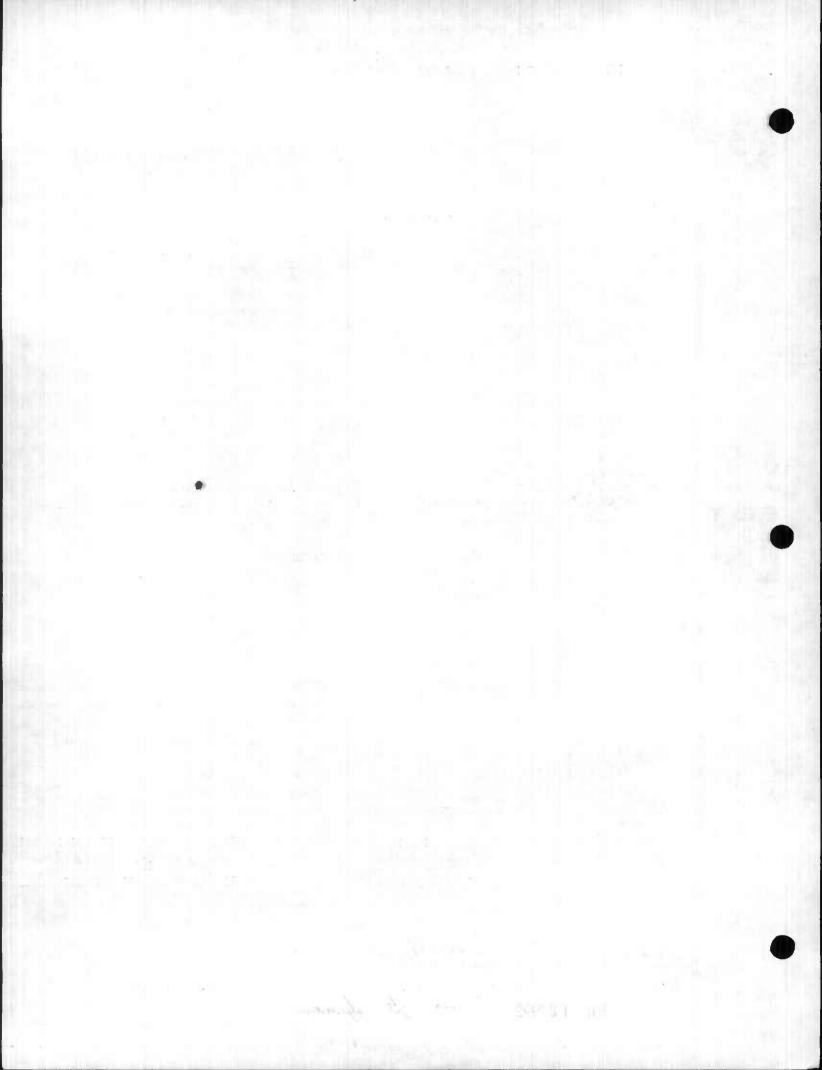
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LINDED TILITS 2	23a	& 26 G773 P				Certific	cate of	Death		Reg. No.	- 1-4	1700
Physici /Medic		Decedent's Name	EVELEN		LOUD				2. Date of De Month	Day	Year 999	3. Time of Death
Examir	ner		rnot institution, giv Llaway ar	re street and number) VE (EEd	ler care	. home0		4b. City, Town, or Lo BALTO	ocation of Dear		of Death	and the state of
Funeral Director		5. Social Security No. 250-34-2. Usual Residence of	353	Sex 7. Ag	pe (In yrs. last bi 84		Inder 1 Year oths Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	rth ny, Year) –1915		lace (State or Foreig S.C.
anytand show id.al		10a. State	10b. County		10c. City, Tox	wn or Location	,		20		1	0d, Inside City Limit
with the Maryland a or 28a-f show be notified at	otor	MD		MORE CITY	BALT	IMORE						1 Ves 2□N
th with the sales of 2 and the m	Funeral Director	501 DOL	.PHIN ST.	00		10	21217			10g. Citizen of U.S.		stry?
15-0020 72 hours after death with the Maryla naturel", or flerne 23a or 23a-f shor idical Examiner must be notified at	by	11. Marital Status Never Marrie 3 (Wildowed		12. Was Decedent Armed Forces? 1 Yes & If Yes, Give Year or Dates:			Decedent of H specify Cubi es & No	tispanic Origin? (Spi an, Mexican, Puerto Specify:	ecity Yes or Ni Rican, etc.)		os - Americ ck, White, AFR. A	
Maryland 21215-0020 d.2 should be filed within 72 hours at the and Merial Hygiene. The marked other than "natural", or traumatic event, the Medical Exam.	Completed	(Speci	15. Decedent's Entry only highest grandary (0-12)	ducation ade completed) College (1-4or		a. Decedent's (Give kind o life. DO NO DOME.	of work done OT use retires	estion during most of work d)	ing	16b. Kind of B		duatry
and 2. be filed w ital Hygie d other if		UNKNOWN 17. Father's Name ())		DUME	3110	18. Mother's Name	e (First, Middle		STIC	
arylan should be and Mental marked or umatic eve	To Be	PETER	BRUNSON	I				LUANNA				
Maryla d 2 should th and Mer 7 is marke traumatic		19a, Informant's Na			190	b. Mailing Add	dress (Street	and Number or Run	al Route Numb	er, City or Town	State, Zip	Code)
		20a. Method of Disp 1 Deurial 2 D	Ocremation 3 [Removal from/State	20b Place cemete	of Disposition Bry, crematory	(Name of or other place	7.5	Date	MI FL 33		eri, State
Baltimore, permit. Pages 1 ar Department of Hea Important: If Item 2 any injury or other once.		4 □ Donation 21_Signature_of-Free	5 DOHer (Specif	- //	MAD NA	200	ne and Addre	es of Facility EST		LAUREL THERS FU	NERL	номе
		23a Farti. Enter th	disease, or com	plications that caused one cause on each is	(furesett) Do			PLACE BAL			7	Approximate Interval Between
Box 68760, Restricted to the same of the s	n/Medical Examiner	Sequentially list con # any, leading to im- cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	iditions, mediate tying niury	b. DI	Due to (or as a ABETES Due to (or as a	consequence	e of):	Disqui	55			
O. B.	Physician/M	Part II. Other signific	cent conditions o	ontributing to death b	ut not resulting i	in the underly	ing cause giv	ren in Pert I.	23b. Dld	tobecco use co	ntribute to	the cause of deat
1S, P.O.	by Phy	Dia	betas						1 🗆	Yes 2□ No	3 Prol	bably 4 Unkno
ecords aw requires ss been sign 2 should be	Completed t	Con	restson	fleat Fo	alung	2			24e. Wes	s en autopsy ormed?	co	are eutopsy findings ailable prior to mplation of cause daeth?
Vital Rec	Com	BA	east 6	Cauca!	-				10	Yes 2010	10	Yes 22 No
- 5 00	n: To Be	exeminer? 1 Ves 221	No	Hospital:	ent 2 ER/O	utpetient 3	DOA Oth	4 □ Nursing Ho	ma sahes		nar <i>(Specif</i>	ELDER CARE
Division of the Hospital or Attending Phyminia 24 hours effect death. Cathe Funeral Director: Affer this completely filled in by the funeral	Certification:	1 ☑ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	5 Panding Investigation 6 Could not be determined	n a con Blass of lai	urv - At homa, fa	Injury M arm, street, fa	1 🗆	Yes 2 □ No	28f. Location ((Straat end Numl wn, Stete)	ber or Rure	l Route Number,
Hospital of 4 hours of -uneral Diely filled is	edicai Ce	(Uneck only	12 CertifyIng Ph	ysicien: To the bast of	of my knowladge	a, daath occu	rred at tha tin	ma, data and place,	and dua to tha	ceusa(s) and ma	annar as si	ated.
o the l	Med	one) 29b. Signature end t		end mennar sta	ated.		29c. Licens			29d. Date signe		
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		30. Neme end eddra		complated cause of d		(Type, Print)	Don	Bouse (4: mod		7/6	199	



State of Manyland / Department of Health and Mantal Hydiana

hysician	1. Decedent's Nam								2. Date of D Month	Day	Year	3. Time of Death
/Medical	Deandre 4a Facility Name (I			number)			4b	City Town or	JULY Location of Dea	7. 199	99 nty of Death	
Examiner		Y MEDIC	-					BALTIM		40.000	nty or Double	
uneral	5. Social Security N	lumber (6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Y		If Under 24 Hrs		irth ,	9. Birth	place (State or Fore
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 2. Dete of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death Month KICHARD 1999 16:45 PM OWENS JULY 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SINAI HOSPITAL N/A 8. Date of Birth Sept. 20, Year 935 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplaca (State or Foreign Cour Maryland 7. Age (In yrs. last birthday) Months Daya Houra 10M 20 F 63 Yrs. 218-30-7060 Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3904 Bateman Avenue 21216 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yas No II Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - Amarican Indien, Bleck, White, etc. 1 Never Married 2 Merried Black 1 Yes X No Specify: 3 Widowed 4 Divorced Yaar or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Building Maintenance Supr. 12th Church 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Raymond R. Owens Clara Viola Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) Dorothy A. Owens (Wife) 3904 Bateman Avenue Baltimore, Maryland 21216 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cramation 3 Removel from Stete Woodlawn Cemetery 07/13/99 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility Caple Funeral Service 21. Signature of Funeral Service Licrosee 5502 Winner Avenue Baltimore, Maryland 21215 Inter the disease, o complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, or haart failure. If st only one cause on each line. Approximate Intervel Between Onset and Death Immediete Cause (Finei EPSIS diseese or condition resulting in deeth) Due to (or as a consequence of): RESPIRATORY FAILURE Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): EMPHYSEMA Due to (or as e consequenca of): Part II. Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown COLONIC PERFORATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? THROMBO CYTOPENIA 2 No 1 Yes 2 No 1 ☐ Yas 25. Wes casa referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending t □ Yas 2 □ No investigation 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide

ician and burial-transit physician s the burial Division of Vital Records, P.O. Box 68760 Physician/Medical signed by t d be detact Completed peed Be 10 this funerel Certification: After ne Hospital or Attending n 24 hours after death.

To the Hosp within 24 ho To the Fune completely fi

DHMH 16 Rev 6/95

Physician

/Medical

Examiner

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or ther any injury or other traumatic event, the Healtest Examinations.

Physician /Medical

Examiner

Examiner

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29a, Certifier (Check only one)

29b. Signature and title of certifian

Baltimore, Maryland 21215-0020

with the Maryland

death

State Registrar

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R. BOWERS, MD JAMELLE 31. Dete filed (Month, Dey, Year) JUL 1 2 1999

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30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

SINAI HOSPITAL 32. Registrar's Signardra souls

RESIDENT PHYSICIAN

ORIGINAL

29d. Dete signed (Month, Day, Year)

21215

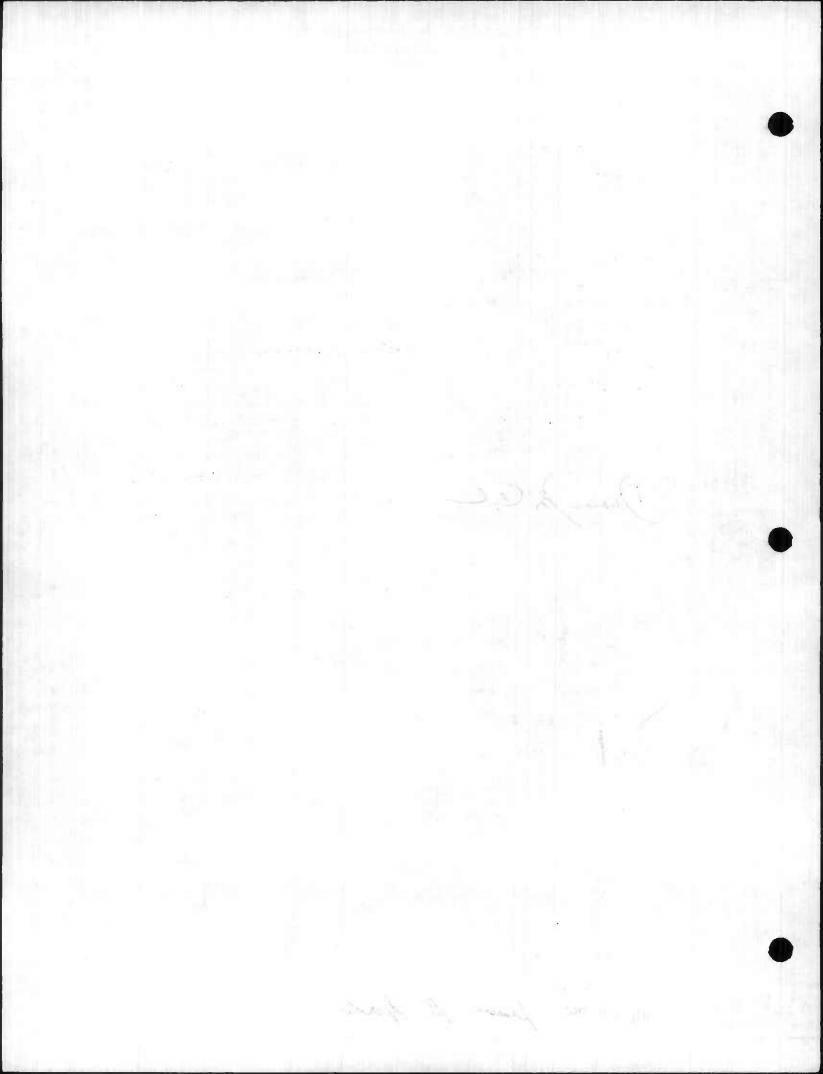
12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner stated. 29c. Licanse number

RES-001

BALTIMORE, MD

JULY 8, 1999

2101 WEST BELVEDERE



State of Maryland / Department of Health and Mental Hygiene 9 2 7 7 1

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xaminer	4a	Facility Name (If not institution	on, give s	street and number	er)			4	b. City, To	wn, or Lo	cation of Deat	4c. Count	y of Death	
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DHMH 16 Ray 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Data of Death Month Day **Physician** laudette 7:00 AM Pickett July /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAHAHO IC
If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year)
OCH 31, 1938 CONTER 1BGRT4 MEDICAL Il Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□M 28TF Months 236-60-7250 14910 Director **Usual Residence of Decedent** 10b. County 10c. City, Town or Location ehow. 10d. Inside City Limits must be notified at 1 Yas 2 No Director BALLINOR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WINCHES TER STREET 2805 Items 23s 212/6 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Bleck, White, etc. the Medical Examiner 1 Never Married 2 Married 21215-0020 "natural", or 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Black Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "nat any highy or other treumatic event, the Healts page. OPACE SUPPLY Elementary/Secondary (0-12) College (1-4or 5+) INSPECTOR 12-75 Grade

17. Father's Name (First, Middle, Last) KEtnil Baitimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumeme) Par line Montgomery KICHARD CHANDLER L. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2805 WINCHESTER STLEET PICKEH HUSKARD ALONZA BALTINUE, Mary Ino 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) HABUTUS, Marylano MEMINA Bra 21. Signature of Funeral Service Licenset 22. Name and Address of Facility CHA-THAZ-HOM'S 5240 KEISTERSTUR · NUMO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction /Medical Examiner Examiner Recurrent physician and the burlei-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last DUDNALY Box 68760, Physician/Medical Due to (for as a consequ 980 23b. Did tobacco usa contributa to the causa of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 s 1 Yes 2 No 2 No 1∏ Yes of Vitai 25. Was case referred to medical axaminer? 8 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2☑ No 1 Inpatient 2 2 ER/Outpatient 3 DOA shis 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: After Division Attending 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fund 1∏ Yes 2∏No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29e. Certifier (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 16 Ray 6/95

31. Date filed (Morith, Day, Year) 121999

30. Nama and address of person who completed cause

GROVGE

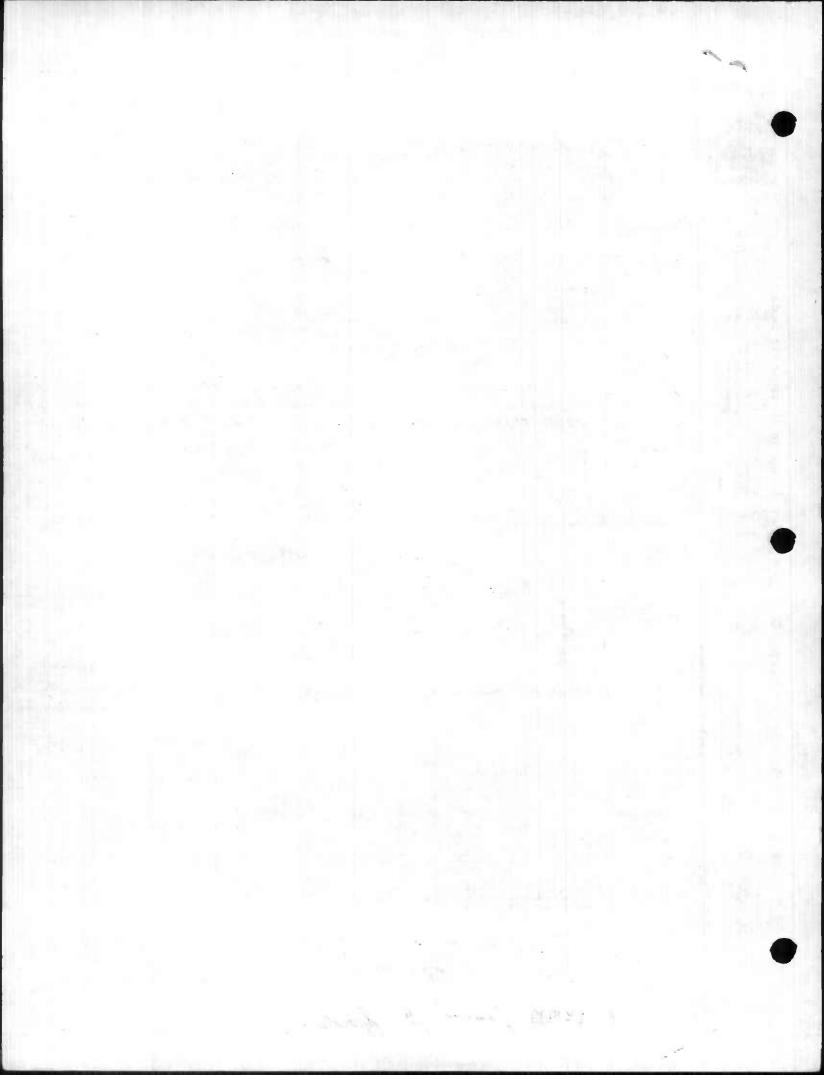
cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

ile M M.D

2600 Liberty Heights Avenus 21215 Sporks

July

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death July 09, **Physician** Lawrence August Panuska 1510 hrs. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 100 M 20 F 218-12-7601 75 Director Nov. 22, 1923 Maryland Usual Residence of Decedent with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow es 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mentel Hygiene. I ferm x21 in marked other than "netural", or flama 23a or 28e-f show t other traumatic event, the Medical Emerican must be notified. Maryland Baltimore Essex Director 1 Yes 2000 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 345 Maple Avenue 21221 U.S.A. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 200 Married TXX es 2 No WWII
If Yes, Give
Year or Dates: aitimore, Maryland 21215-0020 1 ☐ Yes 2 ☑No Specify: awrunce Paruska Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Letter Carrier Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 80 Pages 1 and 2 should be nent of Health and Mentel Frank Panuska Mary Petr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred A. Panuska (wife) 345 Maple Avenue, Baltimore, Maryland 21221 20b. Place of Disposition (Name of 20a. Method of Disposition Dete 20c. Location - City or Town, Stete ery, cremetory or other place) Important: If h any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State permit. Page Department Gardens of Faith Cemetery 7/13/99 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name end Address of Fecility
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service License 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and the buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as P.O. Box 68760 Physician/Medical Due to (or as a consequence of): 2 been signed by the a should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. à 24b. Were autopsy tindings available prior to Completed 24a. Was en autopsy performed? completion of cause of death? page 2 20 No 1 Yes 2 No of VItal or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Y95 2 10 1 Dinpatient 10 2 ER/Outpatient 3 DOA 419 funaral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Division 5 Pending investigation death. 1 TYes 2 □ No ne Hospital or Attendii n 24 hours after death. Ne Funeral Director: A pletaly filled in by the fi 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 19 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical completely (Check only one) To the To the To the F 29d Date signed (Month Day, Year) 29b. Signature and the of could 23a) (Type, Print) ay.

DHMH 16 Rev 6/95

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State Registrar 32. Registrar's Signature

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Certificate of Death	Reg. No.	99	21	77	1
tate of Maryland / Department of Health and Menta	I Hygiene	00	0.1	Street Breeze	

Physician /Medical **Examiner**

Director

Funeral

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Completed

Be

John Thomas Pratt 4a Facility Name (If not institution, give street and number) 11 S. SOMERSET AVE.

1. Decedent's Neme (First, Middle, Last)

4b. City, Town, or Location of Death

Month JULY 06, 1999 1:40 PM. 4c. County of Death

Funeral

6. Sex. 1☐M 2☐ F 5. Social Security Number 716-01-6515 Usual Residence of Decedent

7. Age (In yrs. last birthday) If Under 1 Year Days Months

CRISFIELD H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 8, 191

Somerset Birthplece (State or Foreign Country) Delaware

10d. Inside City Limits

Director

ahow

r than "natural", or items 23s or 28s-f ahov the Medical Examiner must be notified at

ith and Mentei Hygiene. 27 Is marked other than *r r traumatic event, pre Men

Nem 27 H

Department of Important: If It eny injury or or once.

Physician /Medical

Examiner

burial-transit

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signed by the a d be detached f

page 2

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24 hours after death.

Funeral Director: A

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physician the burial

or Attending Physician: The law requires that the death certificate be assecuted

Box 68760.

Division of Vital Records, P.O.

Examiner

Physician/Medicai

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Completed

B

edical Certification: To

Pages 1 and 2 should be nent of Health and Mentel

the Meryland

filed within 72 hours after death

21215-0020

Baltimore, Maryland

10a. State 10b. County Maryland

Somerset

Crisfield

10f. Zip Code

1 Yes 2 No

10e. Street and Number

11 S. Somerset Avenue

21817

USA

10g. Citizen of What Country?

11. Marital Status

, 1 Never Married 2 Merried 3 ☐ Widowed 4 🖺 Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:

84

10c. City, Town or Location

 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify:

14. Race - American Indian. Bleck, White, etc. White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12)

College (1-4or 5+)

18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Railroad

17. Father's Neme (First, Middle, Last)

John Thomas Pratt

18. Mother's Name (First, Middle, Maiden Sumame)

Florence Howard

19a. Informent's Neme/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8716 Cobbler Place

Francis E. Pratt/son

20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 20b. Place of Disposition (Neme of cemetery, cremetory or other place)

Supervisor

Tampa, FL 33615 Date 20c. Location - City or Town, State

Metro Crematory, Inc. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Fyneral Service Licensee

7/10/99 Baltimore, MD 22. Name end Address of Fecility
Cremation Society of Maryland,

aux Dawn McDonald

299 Frederick Road Baltimore, 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

21228 MD Approximate fntervel Between Onset end Death

fmmediate Cause (Final disease or condition resulting in death)

hemorrhage Gastrointestinal Due to (or es a consequence of):

Sequentielly list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last

Due to (or es a consequence of):

Due to (or as a consequence of):

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		10	Yee	2

23b. Did tobacco use contribute to the cause of death? 200 3 Probably 4 Unknown

24b. Were autopsy findings available prior to

24a. Wes an autopsy performed? Limited

completion of cause of death? 12 Yes 2 No 12 Yes 2□ No

25. Was case referred to medical examiner? 1X Yes 2 No

5 Pending investigetion

6 Could not be determined

28a. Dete of fnjury (Month, Day Year)

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work?

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how Injury occurred

26. Place of Deeth (Check only one)

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) end menner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier

29c. License number O.C.M.E.

JULY 07, 1999

29d. Date signed (Month, Dey, Year)

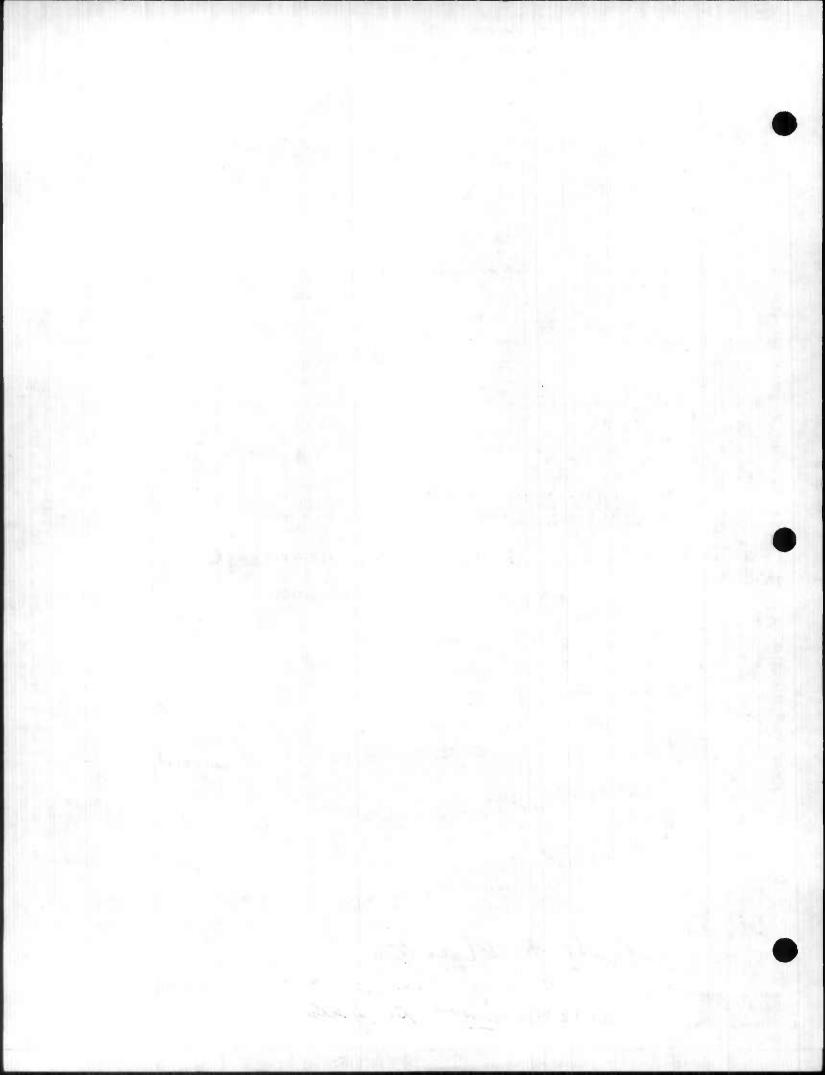
30. Name and address of person who completed cause of death (ttem 23a) Type, Print)

111 Penn Street, Baltimore, Maryland 21201 Stephen 5
31. Date filed (Month, Day, Year) 5. adentz

JUL 12

32. Registrar's Signeture

State Registrar



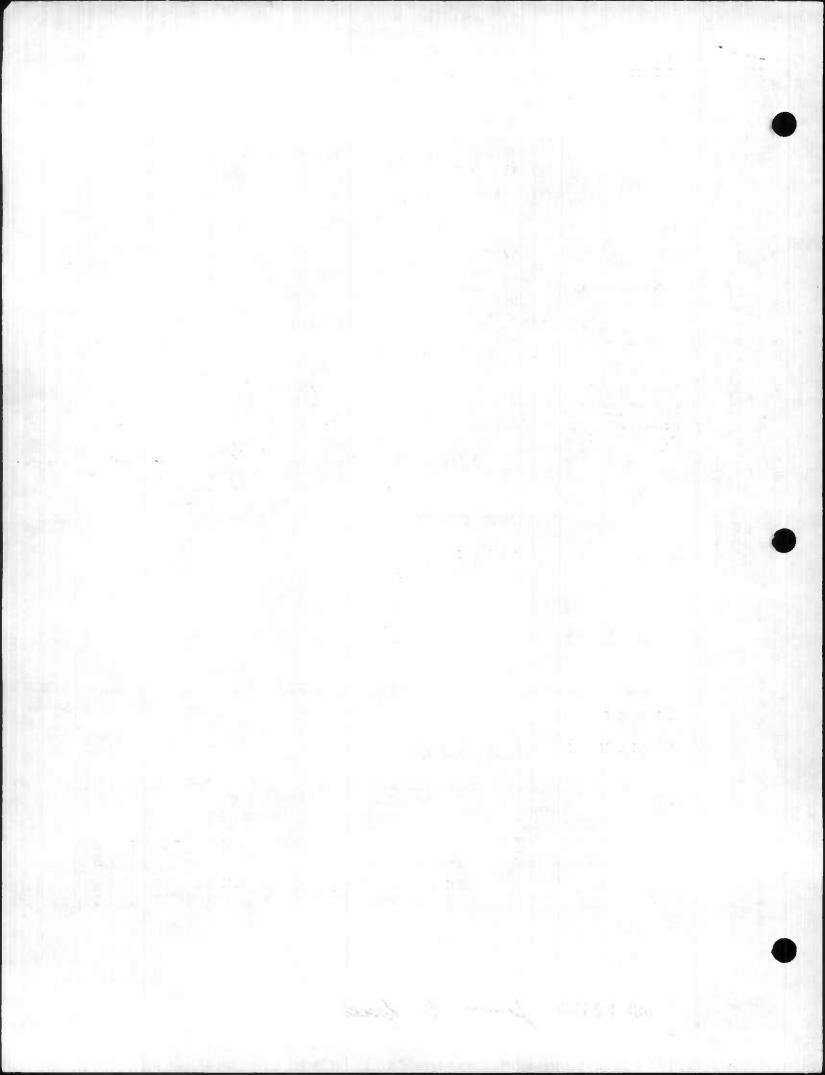
el	ores Beat	trice Queen	State of Maryland	Department	of Health and	Mental Hyg	iene g	9 2	1775
	ITEMS: #23	PART I, II, 27, 28A-F P)		or Death	2. Date of Dea	eg. No.		3. Tima of Death
	Physician	DELORES BO	SATRICE OF	UEEN		July 07	, 1999	Year	7:06 A.M.
	/Medical Examiner	4a Facility Nama (If not institution, give	street and number)			Location of Death	4c. County	of Death	
		3719 Nortonia Road		W Under 4	Baltimo		N/A		
	Funeral Director	5. Social Security Number 6. Sec. 10	7. Age (In yrs. la	Yrs. If Under 1 \ Months D	ear If Under 24 Hrs ays Hours Min		Year)	9. Birthplace	
		Usuat Residence of Decedent				1710910	1//10		7
	ahow	10a. Stata 10b. County	/ b	BALTIMON				100	Insida City Limits
	rect	Hary hno P 1 10e. Street and Number	100	10f. Zip Co		1	0g. Citizen of W	hat Country	
	within 72 hours after death with the Maryland she. Than "nuturel", or items 23e or 28e-4 show the Martical Examiner must be notified a impleted by Funeral Director	3719 Norton	ia RUAD		21216	100	U	572	
	thems 23s		12. Was Decedent Ever in U,S Armed Forces?	S. 13. Was Decedent If Yes, specify	of Hispanic Origin? (\$ Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)		- Amarican k, Whita, etc	
20	or, or learning	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2.2€Ño If Yes, Give Year or Dates:	1 ☐ Yes 2 🖾	(No Specify:		Specify	Bla	Ch
21215-0020	72 hou	15. Decedent's Edu (Specify only highest grad	cation	16a, Decedent's Usual O	ocupation	retina	16b. Kind of Bu	siness/Indu	stry
2	be filed within 72 ho tal Hygiene. I other than "nature event, me Hedical Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	IHA. DO NOT USO T	lone during most of wo etired)		Balhu	in C	ty
	whould be filed withing the Mental Hygiene. marked other than matic event, me it. To Be Comp	17. Father's Name (First, Middle, Last)	J F	IGACIOC	18. Mother's Na	me (First, Middle, I	Nub/IC Maiden Sumam		10012
lan I	Alental formal f	HOWARD R. QU	EEN		Flores	nce Ik	284		
Maryland	0 2 2 3	19a. Informant'a Name/Relationship (Ty	1	19b. Mailing Address (S 3719 Nor	treet and Number or R	ural Route Number	City or Town,	State, Zip C	ode) 21216
	the the the the the the the the the the	20a. Mathod of Disposition		3719 //or			20c. Location -		
Baltimore,	Pages nent of h int: if he iry or of	1 Surial 2 Cremation 3 R 4 Donation 5 Other (Specify)	lemoval from State	matary, crematory or othe	r place)	7/10/0	-		Mary low
	mit. Pa sartmen cortant: Injury	21. Signature of Funarat Service Lighting		BUTUS MON 22. Name and A	ddress of Facility	12.	11/136	erit.	F. 14.
ñ	Page 8	Jan Low	i	5240 R	ddress of Facility C EISTENSTU LONG PREN	WA RUA	2215		
9		23a. Part. Entar the disease, or complishock, or heart failure. List only or	ications that caused the death.	Do not entar tha mode or	dying, such as cerdia	c or respiratory arr	est,	A	pproximata iterval Between
	Physician /Medical	Immediate Cause (Final							Insat and Death
	Examiner	disaasa or condition rasulting in death)	HYPERTHERMIA	-0.					
	D # C		Due to (or	as a consequence of):					
	be executed sicien and burial-transit	Sequentially list conditions, It any, leading to immediate	Due to (or	as a consequence of):					
60,	P G G	Sequentially list conditions, It any, leading to immediata couse. Enter Underlying Cause (Disease or Injury that initiated events	Due to fee						
		rasulting in death) Last	Dua to (or	as a consequence of):					
ROX	es that the death certifice igned by the attending ph be detached for use as th by Physician/Med		1					1	
5	the a ched the a ched f	Part II. Other significant conditions con	tributing to death but not rasu	ting in tha underlying caus	e given in Part I.				he cause of death?
7	es that it igned by be deta by Ph	SCHIZOPHREN IA				1 U Y	es 2 No	3 Probe	bly
cords		MYOCARDIAL FIBROSIS				24a. Was a perform		24b. Ware	autopsy findings
O O	D 20 K	MIOCARDIAL I IBROSIS							oletion of causa
	certificate he irector, page 3					DEV	es 2 No	DET	res 2□ No
VII	Physicism: this certificate director.	25. Was case referred to medicat examiner? 1 XYas 2 No	lospital:	2010 4-15-14 20 004	Other	ath (Check only or		. (014-1)	
סר	g Physic er this conseri dire in: To	27. Manner of Death	28a. Data of Injury	R/Outpatient 3□ DOA 28b. Time of A 28c.	tnjury at Work?	Home 5XI Reside			
SIOL	Attending Phy or death. ector: After this by the funeral iffication: T	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	Found (Month, Day Year) 7-7-99	6:45 M	1 Yes 2 No		ENTAL HEA		
	tal or Attending P rs after death. el Director: After t led in by the funer: Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, street, factory, of	fice	28f. Location (Si City or Town	treet and Number, State) 371	9 NORTO	NIA ROAD
_		29a. Certifier 1 ☐ Certifying Phys	HOME sician: To the best of my know	fedge, death occurred at the	ne tima, data and place	BALTIMORE e, and due to the c			ed.
	F C F Q 0		ner: On the basis of examination and manner stated.						
	To the comple	29b. Signature and titla of certifier	01-	29c. Li	cense number		9d. Data signed		
		Clemis de	Cheet his		O.C.M.E.		July 07	, 1999	
		30 Nama and address of person the co	mpleted cause of death (ttem		nn Street,	Baltimo	re. Mar	vland	21201
		01/11/00		4					

Registrar

JUL 12 1999

22. Registrar's Signature Sparks

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** July 6, 1999 8:00 Pm Tobias Lee Quesenberry Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not institution, give street and number, **Examiner** Upperco Baltimore 15615 Hanover Pike If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Deys Hours MM 2□ F Yrs. **Director** MD 56 215-40-2177 Usual Rasidence of Decedent with the Marylend 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show trsumstic event, the Medical Examiner man be notified at 1 ☐ Yes 2 No Directo MD Upperco Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA permit. Peges 1 and 2 should be filed within 72 hours effer death v Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other trsumatic event, the Medical Examinations. Funeral 21155 15615 Hanover Pike 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give Year or Dates: 14. Race - American Indien. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, Whita, atc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: à 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) Collega (1-4or 5+) Caldor stock manager 10 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Dorothy H. Peltzer 2 Tobias Lee Quesenberry Sr. 19a. Interment's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 32931 757 Nassau Road Cocoa Beach, F1 sister Wilma Quesenberry 20b. Place of Disposition (Name of cometary, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Carroll Cremation Service 7/10/99 Hamstead, MD 21. Signeture of Funeral Service Liberar 22. Name and Address of Fecility any in 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 23a. Part. Enter the disease, or complications that caused the daeth. Do not antar the mode of dying, such as cardiac or respiretory arrest, shock, or hear failure. List only ona causa on each line. Approximata Intarval Between Onset and Death Physician 15/01 Wound To Head /Medical tmmediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or as e consequence ot): Examiner The law requires that the death certificate be executed physician and s the buriel-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated avants rasulting in daath) Lest Due to (or as e consaguença ot): Physician/Medicai Due to (or as e consequence ot) 88 ettending p for use as signed by the e 23b. Did tobacco usa contributa to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part t. 3 Probably 47 Onknown 1 Yes 2 No by 24b. Wara autopsy tindings available prior to should should 24a. Was an autopsy Completed completion of cause of death? page 2 s 1 Yes 2 No 1 Yes 2 No certificate director Be 25. Was case reterred to medical 26. Place of Death (Check only one) exeminer? 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Mesidence 6 Othar (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Date of Injury (Month, Day Year) July 6/999 within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28b. Time of Describe how injury occurred Colound of 28c. Injury et Work? Certification: 1 Naturel 5 Panding 8:00 1 Yes 2 No invastigation 2 Accident Location (Street and Number or Rurel Route Number, City or Town, State) 156 15 HAMOVER PIKE 28e. Place of Injury - At home, tarm, street, tectory, office building, atc. (Specify)

Division of Vital Records, P.O. Box 68760, or Attending Physician: Hospital To the Vithin 2

> State Registrar

edical

3 3 Suicide 4 Homicida

(Check only one)

29b. Signature end title of certifier

29a. Certifier

30. Neme and address of person who complated cause of deeth (Item 23e) (Type, Print), WNELLKI Flegistrur's Signatura

Home

ounellow

6 Could not be determined

Il Hamlet HellRd Baltimore

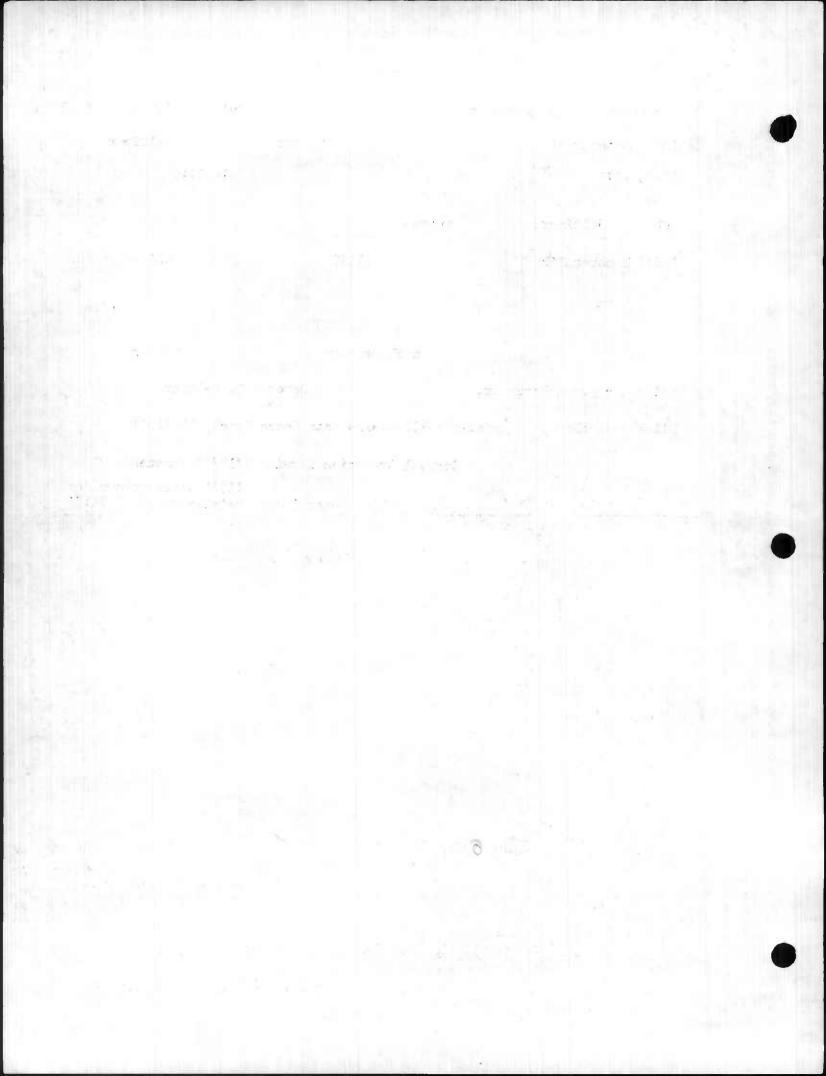
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the causa(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at tha tima, data end placa, and due to the cause(s) and mannar statad.

29c. License number

UPPERCO, MD 21153

29d. Date signed (Month, Dev. Year)

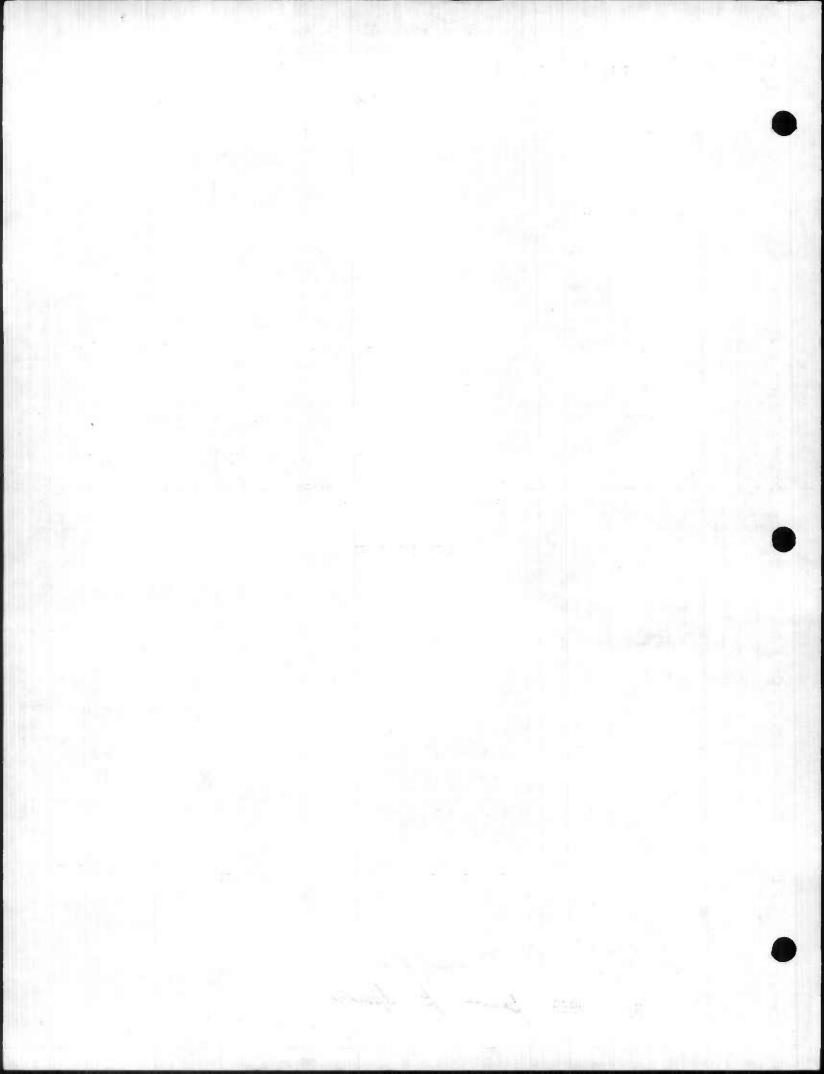


B.K.S State of Maryland / Department of Health and Mental Hygiene, UNKNOWN 99-150 AMEND: ITEMS: #23 PART I, 27, 28A-F PER MEO G773 7-23-9 Certificate of Death Reg. No. 1. Decedenl'a Name (First, Middle, Last) 2. Deta of Deeth 3. Time of Death Month Dey **Physician JAMES** FRANCIS RAWLE 8, 1999 0645 AM july /Medical 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE N/A 4719 PARK HEIGHTS AVENUE - INSIDE AUTO If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours MM 2DF 138 44 8274 Director 34 May 22, 1965 Germany Usuei Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limita 1 Yes 2 No Directo Illinios Champaign Urbana 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð mant be. 7 Florida Ave. 61801 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 📉 No If Yes, Give 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White Specify: à 3 Widowed 4 Divorced Yeer or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Construction 12 Carpenter 17 Father's Neme (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 aboutd be fit ment of Health and Mental H lant: If them 27 is marked off jury or other traumatic even Be Rawle, III James Margaret E. Gray 19b. Melling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 19e. Informent's Neme/Relationship (Type, Print) Margaret E. Rawle / Mother 4340 Roland Springs Dr., Baltimore, MD 20b. Piece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition
1 ☐ Burial 2 ☐ Cremelion 3 ☐ Removel from Stete Dete 20c. Location - City or Town, Stete 7/12/99 4 ☐ Donetion 5 ☐ Other (Specify) Green Mount Crematory Baltimore, MD 22. Nama and Addrass of Facility
CAFA Stephen D. Lohrmann P.A. 21. Signature of Funeral Service License 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Pert1. Enterfihe disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Cause (Finel disease or condition resulting in death) /Medical NARCOTIC INTOXICATION Examiner Due to (or es e consequence ot) Examine The law requires that the death certificata be executed sician and a burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical physi the b Dua to (or as a consequence of) 98 use i P.O. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown Records, ģ 24b. Were autopsy findings eveilable prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed page 2 s certificate Division of Vital or Attending Physician: Be 25. Was cesa referred to medicel axaminer? 26. Place of Death (Check only ona) XXYes 2 No Other: 4 Nursing Home 5 Residence XXOther (Specify) AT SCENE Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28b. Time of Injury 27. Menner of Death 28d. Describe how Injury occurred 28c. Injury at Work? 28a. Dete of Injury (Month, Day Year) 1 DNaturel 5 Pending 1 Tyes 2XXNo UNKNOWN within 24 hours after death. To the Funeral Director: A invastigation 7-8-99 UNKNOWN 2 Accident 6 Could not be datarminad 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 4719 PARKHEIGHTS AVE. filled in by 4 Homicide FOUND IN AUTO BALTIMORE, MD Hospital 1 Certifying Physician: To the best of my knowledga, death occurred at the time, date end place, and due to the ceuse(s) and mannar as stated.

Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edicai 29a. Certifian completely (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) JULY 8, 1999 O.C.M.E and address of person who completed ceuse of deeth (Item 23a) (Type, Print) Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

2. Registrar's Signeture

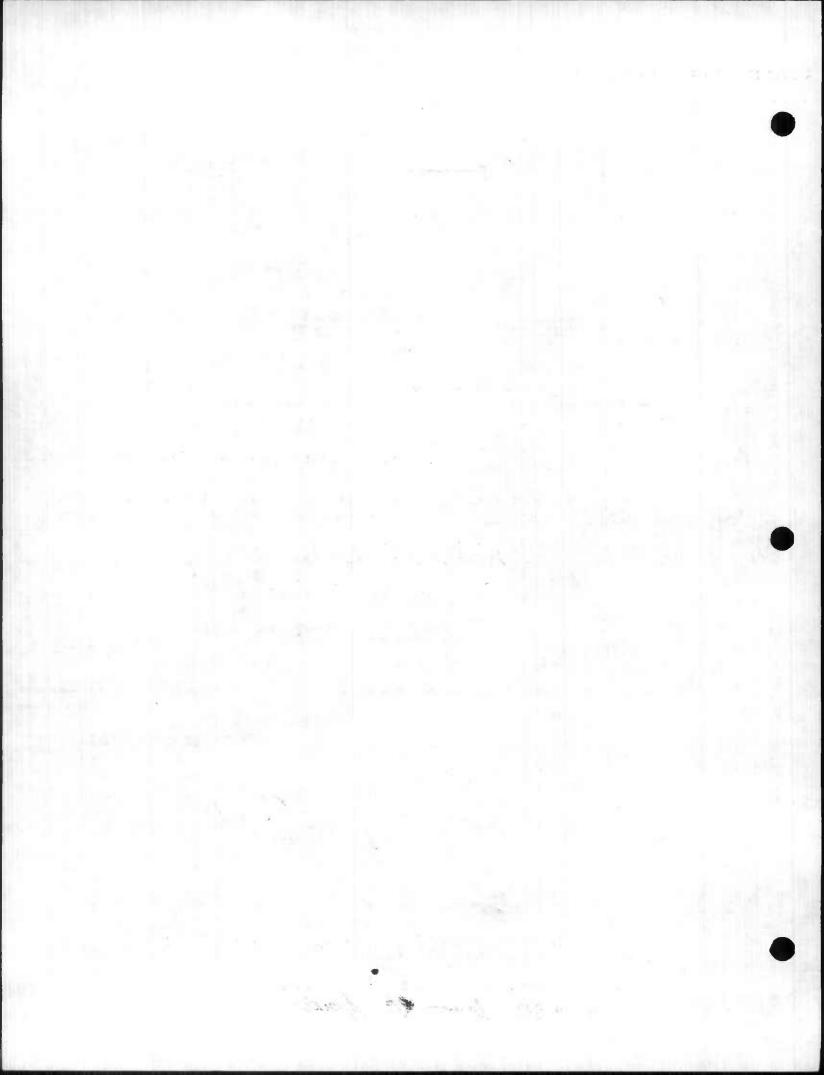


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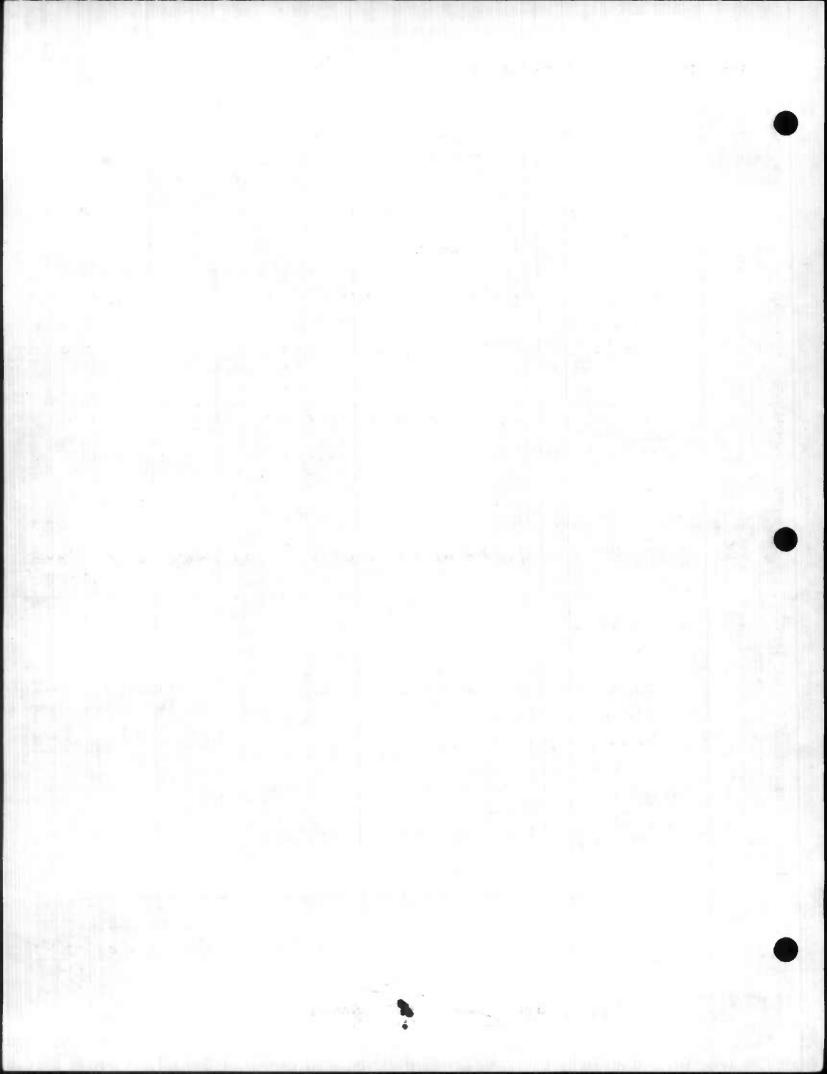
Funeral Director	El 4a Facility Nama (If not institution, giv	mma	277				Month		Year	
Examiner uneral irector	4a Facility Nama (If not institution, giv		Kar	nbo			July	B 1		4:33 A.M
irector	100 0				4		r Location of Dear		of Death	
irector	128 Greenland				Hadar 1 Vans	Pasade			Arun	
	5. Social Security Number 6. S 216-12-6375 Usual Rasidence of Decedant	ex 200 F 3-	ga (In yrs. las		Under 1 Year onths Days	Hours Mi		rth ay, Year) 5-23	9. Birthpla Gountr Mal	yland
-	10a. Stata 10b. County Maryland Anne Ar	undel	10c. City, Town or Location Baltimore					10d. în		
0 4 0	10e. Street and Number 128 Greenland Be	each Road		1	0f. Zip Code 2122	6		10g. Citizen of V U•S		у?
D	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forcas? 1 Yas 2 4 If Yas, Giva Year or Dates:	Evar in U.S. No		Decedent of H is, specify Cube Yes 2 No		(Specify Yas or Nerto Rican, atc.)	o- 14. Rac Blac Specify	e - America ck, Whita, et Whi	
rivgiene. ord, tre Proceeding end, tre Proceeding end, tre Proceeding end end end end end end end end end end	15. Decedant's E (Specify only highast gra Eiamentary/Secondary (0-12) 12th	lucation da complated) Collega (1-4or	5+)	16a. Decedent (Give kind lifa. DO I		ation during most of w d)	vorking	16b. Kind of Bu		istry
the fire	17. Fathar's Nama (First, Middla, Last)					18. Mother's N	ame (First, Middle	e, Maiden Surnan	10)	
5 00	Tv.	illiam J.	Geiss	elman			Florence	Fritze		
th and Mental I	19a. Informant's Name/Relationship (Type, Print)		19b. Meiling A	ddress (Street	and Number or i	Rural Route Numi	ber, City or Town,	State, Zip C	Code)
saith ar or trau	William Rambo /	' Son		307 Gr	een1and	Beach :	Road Ba	ltimore,	Mary	land 212
	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		cem		ory or other place		Deta 7/12/99	20c. Location - Glen B		m, Stata , Maryla
Department of Important: If I any injury or once.	21. Signatury of Funeral Service Loer	yone e			ama and Addre	ss of Facility ie High		Funeral timore,		
ng physician and as the burial-transit Medical Examiner	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last	b. <u>Cs</u>	Dua to (or as	s a consequent	ce of):	dise	eneus L	Jan		
d by the attending etached for use as Physician/Me	Part II. Other significant conditions of	dontributing to death b	out not rasultir	ng in the under	tying cause giv	en in Part I.	23b. Did	I tobacco use co	ntribute to	the cause of deat
igned by the a be detached f							10	Yes 20 No	3 Probe	ably 4 Unkno
s been s 2 should pleted							24a, Wa perl	s an autopsy formed?	COM	re autopsy finding: ilable prior to apletion of cause eath?
Com							1 🗆	Yes 2 No	10	Yes 2□ No
s certification director	25. Was case rafarred to medicel axaminer? 1 □ Yes 2 No		ant 2 ER	VOutpatient 3	3□ DOA Oth	er: 4 Nursing	Home 5 Res	idence 6 Oth		
	27. Mannar of Death 1 Netural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be					yat k? Yes 2 □ No		how injury occur		
	4 Homicide determined	building, ef					City or To	(Street and Numb own, Stete)		
he Funer pletaly fill edical		ysician: To the best liner: On the basis of and manner st	faxamination							
To the compound of the compoun	29b. Signature and titla of certifiar			0	29c. Licens	e number	,	29d. Date signe	d (Month, D	lay, Year)
	30. Name and addrass of person who	complated ceusa of d	leath (Item 23	3a) (Type, Prig	Di	2390	49	7-8	8-9	9

AHB

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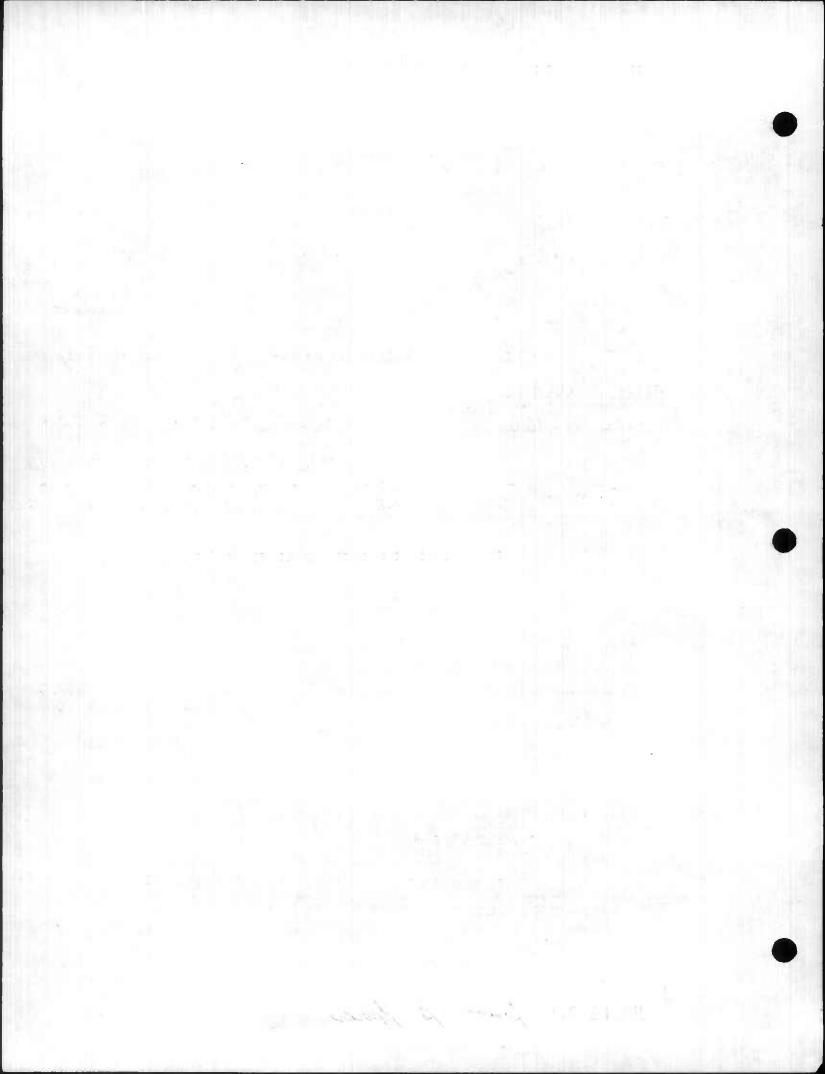
Amended	Item#26 perVerbal MD G7	State of Marylan 73 7/12/99 EW	Certificate			Reg. No.	2	119
Physician	Decedent's Name (First, Middle, Last, Nancy	Sampso	on		2. Date of De Month June	Day 28,	Year 99	3. Time of Death 12:00N
/Medical Examiner	4a Facility Name (If not institution, give Church Home	street and number)		4b. City, Town, or Baltin	Location of Death		of Death	22.001
Funeral Director	5. Social Security Number 6. Sec. 220-05-9066		last birthday) If Under		8. Date of Bir	th ly, Year)		e (State or Foreign
iano maria	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Location				10d.	Inside City Limits
with the Maryla to cite-fatow be notified at Director	MD NA	Bal	ltimore					1½ Yes 2□No
In with the Ma 23a or 28a-f s at be notified at Director	10e. Street and Number 633 Aisquith St	treet Apt.19	5-K 10f. Zip (Code . 202		10g. Citizen of W USA		?
20 safter death v or itsens 23s sminer mast	1 Never Married 2 Married	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2X No If Yes, Give	S. 13. Was Deceded if Yes, special 1 Yes 2	ent of Hispanic Origin? (fy Cuban, Mexican, Pua No Specify:	Specify Yes or No rto Rican, etc.)		- American k, White, atc	
215-0020 thin 72 hours at a "natural", or Medical Exam	3 Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:	16a. Decedent's Usual	Occupation		16b. Kind of Bu	Blac	
Ind 21215-0 be filed within 72 ho tal Hyglene. d other than "natur event, the Medical I Be Completed	(Specify only highest grade Elementary/Secondary (0-12) 2nd Grade	e completed) College (1-4or 5+)	(Give kind of world life. DO NOT use	done during most of wo retired)	orking			
High will have the mit, the Corr	2nd Grade 1	NA	assembl	y worker	ma (First, Middla,			ning Co.
0 9569 0	George	Fulgham		Nancy		Crum		
一 日本の日	19a. Informant's Name/Relationship (Ty Ernest	pe, Print) Scott		(Street and Number or Fi				
ore, not health lisen 27	20a. Method of Disposition		laca of Disposition (Name emetery, crematory or of	e of her place)	Date	20c. Location -	City or Town	, State M D
Illmore, It. Pages 1 at Imment of Hear Ident: If Item:	1X Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		edar Hill		07-02-	99 Anne	Arun	ndel Co.
Depart Depart Import any in	21. Signature of Funeral Service License	2		Address of Facility E				d 21202
	23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the death ne cause on each line.					Ar	pproximata tarval Between
Physician /Medical Examiner	Immediata Causa (Final disease or condition resulting in death)	ARTER 10 Due to (or	SCLER	TLE CAR	100 VA	1SCULA,	101	SEASE.
5	Tooding it coulty	Due to (or	r as a consequence of):					YGARS
cate be executed physicien and the bunie-transit and call Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	r as a consequence of):		16			
Phys strage	cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a consequence of):			-		
P.O. BOX 6 tet the deeth certification of the estending lettached for use as Physician/Me		J						
yalci	Part II. Other significant conditions con	stributing to death but not resu	ulting in the underlying ca	use given in Part I.	23b. Dld	tobacco use con	tribute to th	ne cause of death?
	RENAL	PAILVAR	?		10	Yes 20 No	3 Probab	oly 4 Unknown
should be a	HEART F	2ALLUNE	~	3.11		an autopsy ormed?	svalia	autopsy findings able prior to eletion of cause ath?
tal Rec	STNOKE				101	Yes 2 TNo		es 20 No
ortific ector, Be	25. Was case referred to medical examiner?	lospital:		Other	eath (Check only o			
그 등 등 기	27. Manner of Death 1 DrNatural 5 Pending	28a. Date of Injury (Month, Day Year)		Ic. Injury at Work?	Home 5 Resi	dence 6 Other		
IVISION ATTENDED IN ATTENDED IN BY THE	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ma, farm, street, factory,		28f. Location (. City or To	Street and Number wn, State)	er or Rural R	oute Number,
To the Hospital or within 24 hours efte To the Funeral Dir completely filled in Medical Ceri		sician: To the best of my knowner: On the basis of examinational manner stated.						
To the Within To the comple	29b. Signature and title of certifier		29c.	License number		29d. Date signed	(Month, Da	y, Year)
		zem no	(1732	2	VNE.	28,	1999
	30. Name and addrass of person who co	mpleted cause of death (Item	D. CHUN	CH HOSE	1796	BAC	7.1	4D.31
State Registrar	3f. Date filed (Month, Day, Year) 2 1	32. Registrer's Signat	ture :	rocks				



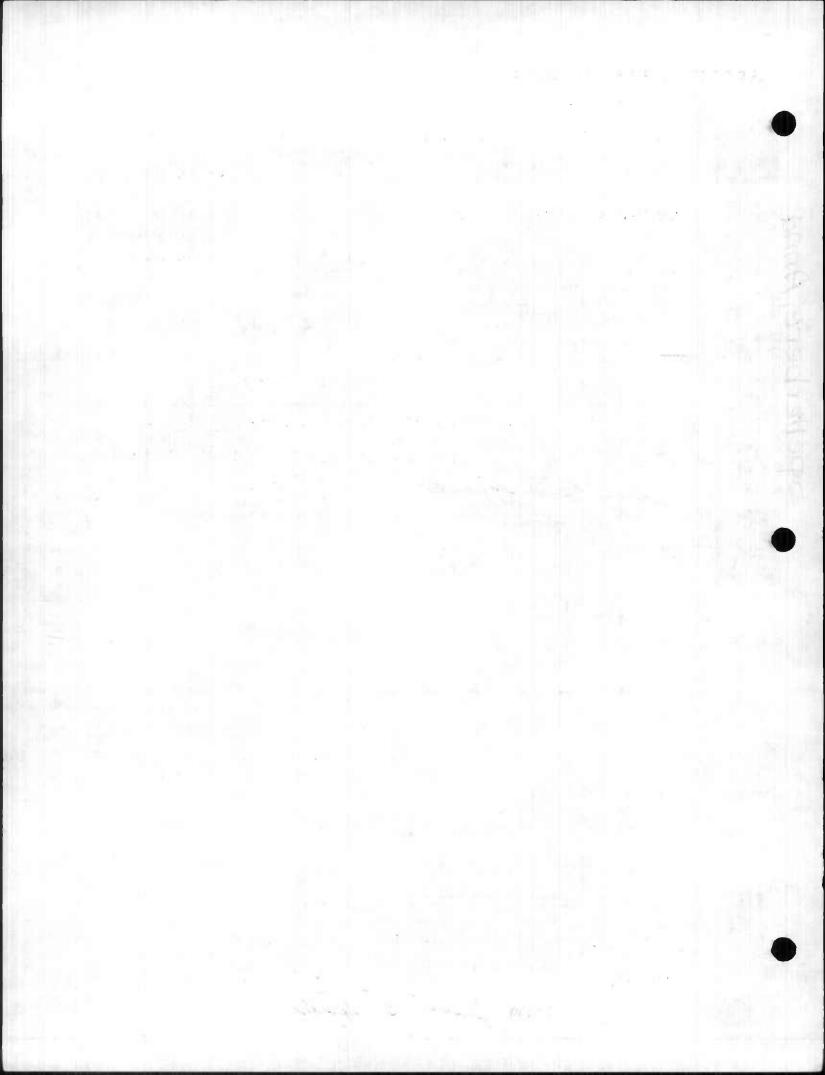
B.K.S State of Maryland / Department of Health and Mental Hygiene
ANTHONY SAVAGE ITEMS: #23 PART I, 27, 28A-F PER MEO Certificate of Death

Reg. No. Mont's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey **Physician** Vaca 8, JULY 1999 11:33 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deal Examiner SINAI HOSPITAL I.C.U BALTIMORE If Under 24 Hrs. Hours | Min. If Under 1 Year Months Days 9. Birthpiece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 215-88-250 Usual Residence of Decedent 150M 20 F Director 10d. Inside City Limits 10a. State 10b. County 10c. City, Toy permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hyplens. Important: if them 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic avent, the Medical Examiner must be notified an edge. 1 Yes 2 No Director 10f. Zip Cod 10g. Citizen of What Country? 10e. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Married Ricax 1□ Yes 20 No Baitimore, Maryland 21215-0020 Specify Specify P 3 ☐ Widowed 4 ☐ Divorced merican Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colleger(1-4or 5+) (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be e/Relationship (Type, Pant) sister City or Town, State, Zip Code) 4021229 20b. Plece of Disposition (Name cometery, crematory or other Method of Disposition 20c. Location - City or Town, State Randalls town, MD Butial 2 Cremation 3 Removel from State 4 (Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 141) 2/2/7 208. Pert 1. Enter the disease, or complications that series of the death, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onsel and Death mode of dying **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical NARCOTIC AND COCAINE INTOXICATION COMPLICATED BY HEAT EXPOSURE **Examiner** Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be assecuted sician and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 physician Due to (or es e consequence of): 94 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributs to the causs of death? 1 Yss 2 No 3 Probably 4 Onknown Records. P 24b. Were autopsy findings Completed 24a. Was en eutopsy available prior to completion of cause of death? performed' 1 Yes 2 No 1 PYes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Yes 2 No XXnpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred D Affer Found: 1 Netural 5 Pending UNKNOWN 1 Tyes 2 1 No death. investigetion 2 Accident Director: 7-7-99 3:30 3 Suicide 6X☐ Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) after 4 Homicide 417 EDSDALES AVE. To the Hospital within 24 hours a To the Funeral D FOUND ON STREET 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner stated. 29e. Certifier 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) JULY 9, 1999 O.C.M.E o completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 taner 32. Registrar's Signature 2

Registrar



AMENDED II	EM #15 PER FH G773 7/12			tificate of		В	eg. No.	6.101
Physician /Medical	Decedent's Name (First, Middle, Last Anna Spellerberg	,				2. Date of Deat Month July		3. Time of Death 2:15AM
Examiner	4e Facility Neme (If not institution, give GREATER BALTIMORI		ENTER	1	TOWSON	ocation of Death	4c. County of BALTIM	
Funeral Director	5. Social Security Number 6. Se 219–28–0074	7. Age (1	n yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day, March 1		Birthplace (State or Foreign Country) Maryland
Maryland I show fad.at	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimor		Oc. City, Town or La	cation				10d. Inside City Limits 1 ☐ Yes 2 🔀 No
or 28a-f s be notified Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh.	at Country?
un atter death v et, or thems 234 Examiner must by Funeral	1 Brett Court 11. Merital Status 1 Never Merried 2 Married 303Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 20 No If Yes, Give Year or Dates:		21221 Wes Decedent of H f Yes, specify Cube I□ Yes 25No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No-		American Indian, White, etc.
led within 72 ho typiene. her then "naturn nt, the Medical.] Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	lent's Usual Occup kind of work done 20 NOT use retired tionist	durina most of work	ing B		Manufacturer
Mental H arked off file ever To Be	John P. Lynch				Anna W		wallerr Surname)	
ss 1 and 2 sho of Health and Item 27 is ma other traum	19a. Informant's Name/Relationship (7) Rev. Michael J. Ca 20a. Method of Disposition	allaghan (r	ep) 617	South Sh	>e)	Date Date	Lmore, Ma 20c. Location - Ci	aryland 21230 ty or Town, Slete
anti. Paga sartment. ortant: If injury or	1 X Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	00v -	Wood Law	Cemeter	ss of Fecility			re, Maryland
S O S S S S S S S S S S S S S S S S S S	23a/Pert1. Enter the disease, or compl	00	1	407 old H		venue, E	ssex, Ma	aryland 21221
Physician /Medical Examiner	shock, or heart failure. List only o Immediete Cause (Finat disease or condition resulting in death)	ne ceuse on each line.	e to (or es e consec					Interval Between Onset and Death
esth certificate be executed attending physician end for use as the burial-transit clary/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	c	e to (or es e consec					
the attenthed for u	Part II. Other significant conditions co	ntributing to death but n	ot resulting in the u	nderlying cause giv	en in Part I.	23b. Dld to	bacco use contr	ibute to the cause of death
\$ 50 E						1 🗆 Y	es 2 No 3	Probably 4 Unknow
aw requires to been a 2 abouid pleted						24a. Was a perform		24b. Were autopsy findings available prior to completion of cause of death?
ystolen: The last certificate he director, page	25. Wes case referred to medical				26. Place of Deat	1 ☐ Ye		1 ☐ Yes 2 No
£ 57	examiner? 1 Yes 20 No 27. Manner of Death 1 Natural 5 Pending	lospital: 1 Inpalient 28a. Date of Injury (Month, Day Yo	2 ER/Outpatier	t 3 DOA Oth	4 Nursing Ho		ence 6 Other ow injury occurred	
To the Heapital or Attanding Physipin 24 hours effer death. To the Funeral Director: After this completely filled in by the funeral Medical Certification; 1	2 Accident investigation 3 Suicide 6 Could not be determined	28a. Plece of Injury building, etc. (5	- At home, farm, str Specify)		Yes 2□No	28f. Location (Si City or Town	treet end Number n, Stete)	or Rural Route Number,
to the Hospital vithin 24 hours to the Funeral completely filled	29a. Certifier 12 Certifying Physical Control one) 12 Medical Exami	sician: To the best of m ner: On the basis of ex and manner stated	amination and/or in	occurred at the tir restigation, in my o	ne, dale end place, pinion, death occur	end due to the cred at the time, d	euse(s) and mann ate and place, an	ner as stated. d due to the cause(s)
To the within To the compl	29b. Signature end title of certifier	Attendo		29c. Licens	9 number 3 7 0 1 6			Month, Day, Year)
	30. Name and address of person who co	empleted cause of death	h (Item 23a) (Type,	Print) Charles J	t. Stite			, my 2/204
State Registrar	31. Date filed (Month, Day, Year)	32. Registar's	Signature	9. Spa	ds.			



Box 68760, Records, P.O. Division of Vital

physician and the burial-transit The law requires that the death certificate be executed attending for use as 2 signed t peen page 2 certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica á To the Hospital or within 24 hours aft To the Funerel Di completely filled in

Physician

/Medical

Examiner

Director

Funeral

à

Completed

Be

Funeral

Director

7 is marked other than "naturel", or items 23s or 28s-f shor traumstic event, the Medical Examiner must be notified at

filed within 72 hours after Hygiene.

pernit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: if itam 27 is marked other than eny injury or other traumatic event. the second injury or other traumatic event.

Physician /Medical

Examiner

Examiner

Physician/Medical

þ

Completed

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^oL

Certification:

Medicai

(Check only one)

29b. Signeture end title of cartitier

Baltimore, Maryland 21215-0020

Maryland

the

State Registrar

31. Dete filed (Month, Dey, Year) 1 2 1999



30, Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Krostin Deam modical onlar oil south charles of Baltimace south

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete and piece, end due to the cause(s) end menner steted.

29c. License number

D30494

29d. Dete signed (Month, Dey, Year) 7/5/96

my) Q1230

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death tansbur Month 11, ponita 1999 JULY 1:20am 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, give street and number) 4c. County of Death 417 David Drive Anne Arundel Arnold If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JULY 19, 1 Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1□M 20XF Days Yrs. 216-44-0708 55 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Arno1d 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 417 David Drive 21012 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Race - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus 1 Never Married 2 Merried 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Secretary Federal Government 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Howard Parr Zelma McKinlet 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 417 David Drive Melvin Stansbury/husband Arnold, MD 21012 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stele 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from Stete Metro Crematory, Inc. 7/12/99 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Fundel Service Licenses 22. Neme and Address of Facility
Cremation Society of Maryland, McDonald 299 Frederick Road Baltimore, MD 21228 23a, Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finei disease or condition resulting in deeth) year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events thet initieted events resulting in death) Last Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tohacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked oth any Injury or other traumatic avent pates.

Physician

/Medical

Examiner

Director

p

Completed

Be

Funeral

Director

77 is marked other than "natural", or items 23s or 28s-f show traumstic avent, the Medical Examiner must be notified at

after

Examiner

27. Menner of Death

2 ☐ Accident

3 ☐ Suicide

4 Homicide

(Check only one)

29b. Signeture end title of certifier

anine

attending physicien and for use as the burial-transit signed by the a After death. after death Director: 6

Box 68760 Physician/Medical Division of Vital Records. þ Completed Be P Certification:

State Registrar

31. Dete filed (Month, Day, Year)

5 Pending investigation

6 Could not be determined

alling, MD

29c. License number 152830

1 Yes 2 No

28c. tnjury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of tnjury (Month, Day Year)

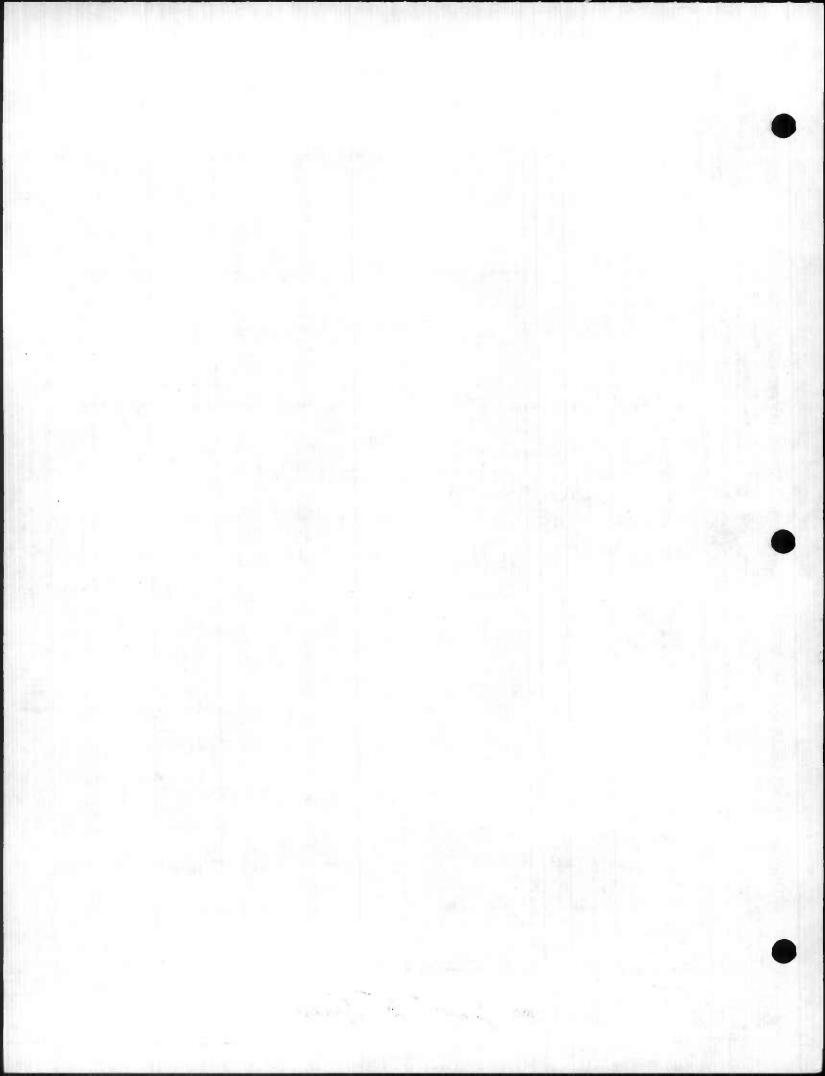
Road, Annapolis, mo 900 Bestoate Jeanine Werner

32. Register's Signature

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

To the Hospital within 24 hours a To the Funeral completely filled



						Cert	ificate of l	Death	R	eg. No.		
			1. Decedent's Name (First, Middl						2. Date of Dea Month	th Day	Year	3. Time of Death
		ician dical	Evelyn	Sci	hultz	2			JULY		999	2:08 P.N
		niner	4e Facility Neme (If not institution				4	lb. City, Town, or i	Location of Death	4c. County	of Death	
	784		GREATER BA	LTIMORE M	EDICA.	L CEN!	TER	TOWS		BA	LTII	
	Funer	al	5. Social Security Number	6. Sex 7. 1 ☐ M 2 ☑ F	Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthp Cour	place (State or Foreign
	Direct	or	570-72-6356	TOW ZX	50	Yrs.			JULY 0	1, 1949		nio
	pu s		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Loca	ation				1	10d. Inside City Limits
	Annyl	ō	MD N/A			Balti						1 □XÝes 2 □ No
	The N	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of V	What Cour	ntry?
	with w			C+ D	0100			1			VII. 0001	My s
2	death with the Maryland me 23e or 28e-f show mast be notified at	era	700 W. 40th	12. Was Decede		13. Wa	2121		pecify Yes or No-	USA 14. Bac	e - Americ	can Indien,
1	2 22	Funeral	1 Never Married 2 Marr	Armed Force	es?			ispanic Origin? (S n, Mexican, Puert	o Rican, etc.)	Bled	k, White,	etc.
7	020	by	3 ☐ Widowed 4 ☐ Divorced	If Vas Gwa		10	Yes 2MNo	Specify:		Specify	· Wh	nite
EVELY	21215-0020 d within 72 hours after desplace. r then "natural", or thems the Medical Estimator.	Completed	15. Deceden	t's Education		16a. Decede	nt's Usuel Occup	ation	tina	16b. Kind of Bu	usiness/In	dustry
Ш	CI E SE	ple	Elementary/Secondary (0-12)	st grade completed) College (1-4)	or 5+)	lite. DO	NOT use retired	during most of wor f)	NIII Y			
	12 Berg	Con	12			Homer	maker			Dom	esti	LC
N	Du # 100 Men	80	17. Father's Name (First, Middle,					18. Mother's Ner	ne (First, Middle,	Maiden Suman	10)	
1	Via Menidia Menidia	P	Oscar T	. Schultz				Dor	nita Bo	nd		
1-	ore, Maryland 212. 18 1 and 2 should be lifed within the lettle and Mentel hygiene. If hearth and worker than other transmedic avent, the lettle		19a. Informant's Name/Relations					and Number or Ru				
7	and and m27		Carl R. Schultz	z/brother	1001 01			h St.				21218
土	Or of He		20a. Method of Disposition 1 Burial 2 Tremation	3 □Removal from Ste	00/	netery, creme	tion (Name or itory or other plac	(8)	Date	20c. Location -	City or To	own, Stata
CHO	Baltimore, Maryland 21 permit. Pages 1 and 2 should be illed wi peperment of Nestle and Mentel hygien important: If term 27 is marked other th eny injury or other treumeds event, the		4 ☐ Donation 5 ☐ Other (S	pecify)	Met	cro Cre	ematory,	Inc. 07	/09/99	Baltim	ore,	, MD
()	Sall emit mpon ny in	Dear	21. Signeture of Funeral Service	ss of Facility n Socie	etv of	Marvla	nd.	Inc.				
0,	m 9079	a	Dawn	Bohald	riwork	29	99 Fred	erick F	Rd. Bal	timore	, MI	21228
	1		23a. Part1. Enter the diseese, or shock, or heart feilure. List	complications that cause only one cause on each	sed the death. h line.	Do not enter	the mode of dyin	g, such as cardiad	or respiratory arr	est,		Approximate Interval Between
	Physicia			Λ							1	Onset and Death
	/Medica		Immediate Cause (Final disease or condition resulting in death)	a PNEU	MONIA							5 days
			resolung an death)			as a conseque	ence of):				1	
	P =	- Ju	Table 1	b								
	and and	Xan	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b									
	58760, icate be executed physician and a the buriel-transit										-	
	x 68760, ertificate be executing physician and its as the buriel-tran	olbe										
		3		d								
	ds, P.O. Bc	Physician	Part II. Other significant condition	nne contributing to deat	h hut not recult	ing in the und	larhana causa ain	on in Part I	23h Did to	shacco usa co	ntribute t	o the cause of death?
	P.O. at the d by the etached	hys	A .	1	•		oriying cause gre	on are are a.	1 🗆 Y	1/		bably 4 Unknow
	F that a deb	by P	PAMYOTROPHIC	LATERAL	xuer	CKO						
	Records, P.O. Bo								24a. Was a perfor		24b. W	ere autopsy findings vailable prior to
		olet							perior	medi	00	ompletion of cause death?
	I Rec	Completed							1 🗆 Y	es 2000	11	☐Yes 2☐ No
		Be C	25. Was case referred to medical					26. Place of Dea	ath (Check only or		1	
	f Vital Rysician: The Is confiltrate had director, page	0	examiner?	Hospitel: 1 Inp	atient 2 E	R/Outpatient	3□ DOA Oth	or	lome 5□ Resid		er (Specia	(h)
	Division of Vital or Attending Physicien: The grade death. Since they this confliction of the by the funeral director, pa	Ë	27. Manner of Death	28a. Date of I		28b. Time of	28c. Injur		28d. Describe h			
	sion o leath. for: Affecth	atio	1 ☑ Netural 5 ☐ Pendin 2 ☐ Accident investig		Day (out)	Injury		Yes 2 □ No				
	Afte octo	H	3 ☐ Suicide 6 ☐ Could determ	ined 288. P1808 01	Injury - At home etc. (Specify)	ne, larm, stree	et, factory, office		28f. Location (S City or Tow	treet and Numb	er or Run	ral Route Number,
	D Paris	Certification:	/ /	bulloling,	etc. (Specify)				Ony or 1011	, olaroj		
	Division of Vita within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29e. Certifier 1 Certifyin	g Physician: To the be Examiner: On the basis	st of my knowl	edge, death o	occurred at the tin	ne, date and place	, and due to the c	ause(s) and ma	anner as a	stated.
	the H the F	P	ane)	and menner	steled.	ar arrow or arrow						
1	With To Too	Σ	29b. Signeture end title of certifie	a O her)		29c. Licens	3 0 4 3 3	2	9d. Date signe	(Month,	Day, Year)
			► /WUL Ø	WY)			D	30475		177/	77	
			30. Name and address of person	who completed cause of	of death (Item 2			1 1.	UIMORY	MI	21	204
			M. INALY IN.U.	UMUC	6101	N CHI	Licres 2	1 '74	UMUKE	/ *[/.		
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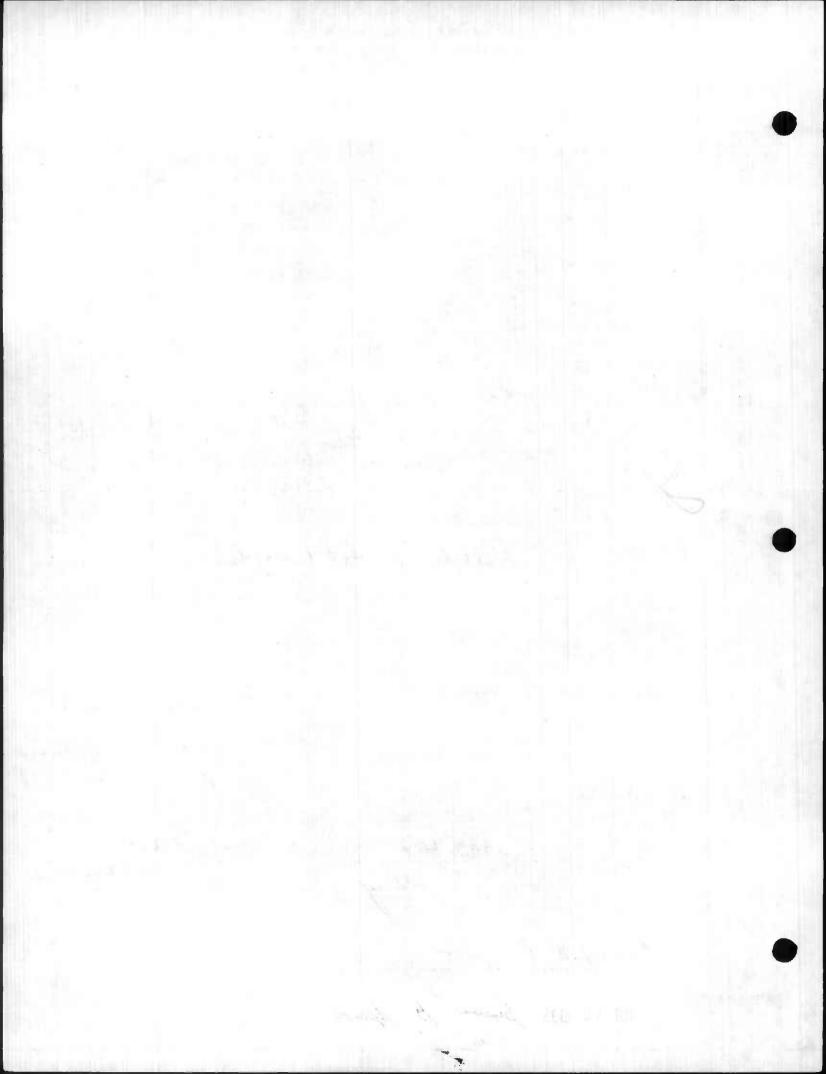
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	UNKNOWN		9-149 State of Maryland / Department of Health an Certificate of Death	nd Menta		ene) 2	1785
	Physiciar /Medica	1	1. Decedent's Neme (First, Middle, Last) Curlenzo C. Stith	2. Dete Mor	of Death		Year	3. Time of Death 0355 AM
	Examine	r	3439 PATON AVENUE- REAR ALLEY BALTI		f Death	4c. County of	N/K	2
	Funeral Director				of Birth hth, Dey, Y	1970		ry land
	72 hours after deeth with the Maryland natural, or items 23a or 28a-f show sical Examiner must be notified at	al Director	10a. State 10b. County 10c. City, Town or Location Manyland N/A Bultmore 10e. Street and Number 10f. Zip Code 2908 Garrison Blvd- Apt. T5 21216		10g	. Citizen of W		d. Inside City Limits 1 ☑ Yes 2 ☐ No y?
5-0020	ours after deet ral', or flama 2 Eramber ma	by runeral	11. Meritel Stetus 12. Wes Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Merried 12. Wes Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P 1 Yes 2 No 1 Yes Give Yeer or Detes: 1 Yes 2 No Specify:	n? (Specify Yes Puerto Rican, e	s or No-		- America c, White, et	
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, In	of Heelth of Heelth I kem 27 r other tr		Novine Stith mother 2101 Dwid Hill 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from Stete 20b. Place of Disposition (Name of cametery, cremetory or other place)	Aue	Bent 20	Amore c. Location - (MO City or Tow	Z/2/7
Baltimore	permit. Pag Department Important: b any injury o		4 Donetion 5 Other (Specify) 21. Signeture of Funerel Service Vicensee 22. Name and Address of Facility P. (1) S.		enal S	Salti, Servic.	e	217
	Physician /Medical Examiner	5	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as call shock, or heart feilure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in deeth) a. Due to (or es e consequence of):	ardiec or respira		3,		Approximete Intervel Between Onset end Deeth
x 68760,	leeth certificate be executed attending physician and I for use as the burist-frensit	8	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or es e consequence of): c. Due to (or as e consequence of):					
, P.O. Box	that the ded by the detached		Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23			tribute to	the cause of death?
Records,	aw requi			246	e. Wes en e		con	a sutopsy findings lable prior to apletion of cause eath?
Vital B	entification octor	3	axeminer/	of Deeth (Check		2□No		7es 2 No
Division of	To the Hospital or Attending Physic within 24 hours after death. To the Funeral Director: After this or completely filled in by the funeral director. Medical Certification: To		27. Menner of Death 1 Netural Nestigetion Suicide 4 Homicide Prosplie: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursi 2	28f. Loc	bke	Injury occurred to the second	or or Rural	AT SCENE Route Number, A Venue
	To the Hospital of within 24 hours at To the Funeral D completely filled if Medical Ce		29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth control of the time, dete end process of examination and/or investigation, in my opinion, deeth and menner steted.	plece, and due occurred et the	to the cause time, date	se(s) and mer e end place, a	long	/
	within To the Comp		29b. Signeture and title of certifier Decodsfe M.		29d	Date signed		
	State		30. Name and address of person who completed caute of death (Item 23a) (Type, Print) Theodore King M.D. 31. Date filed (Month, Day, Year) Will 1 9 1000	imore,	Mary]	land-2	L201	

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ORIGINAL



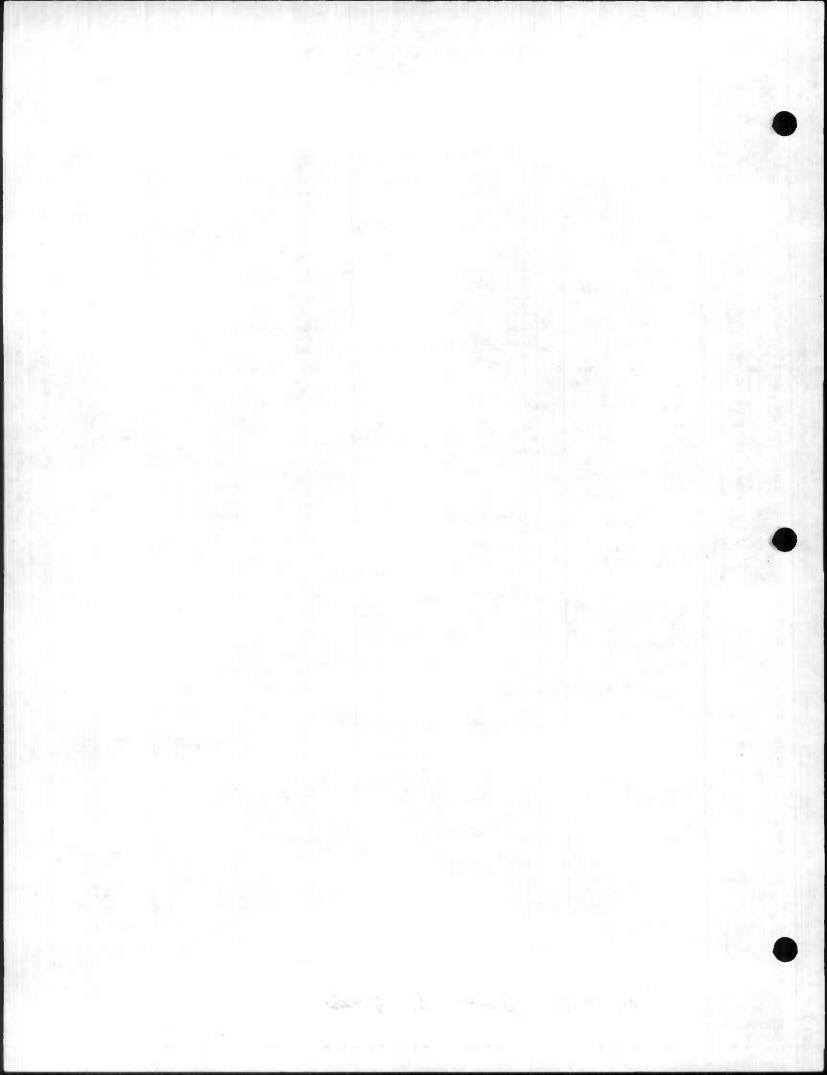
State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Tima of Death Day Month Year **Physician** Alfred SloMAN 8:45 AM JULY 1999 10 /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Church BAltimore HOSPITAL

7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Yaar 5. Social Security Number Birthplaca (Steta or Foraign Country) **Funeral** Months Days 1XM 20F 216-16-8462 Director Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yas 2 No YARY/AND BAltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Street EAST LOMBARD "natural", or Items 23a 21224 U.S.A. 12. Wes Decedent Evar in U,S. Armed Forces? 1 ⊠ Yas 2 □ No If Yes, Giva Yaar or Datas: ₩₩∏ 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc 1 Never Merried 2 Married 1□Yes 2MNo Specify: White p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Shipping CARPENTER 64% 17. Father's Nema (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumame) Be ARthuR SIONAN KICHARD 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SloMAN Street BAlto. Md 21224 WIFC 4215 E. LOMBARD 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 Surial 2 ☐ Cremation 3 ☐ Removal from Stata Heart of Jesus Cen July 13, 1998 BAIT, MORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility
Charles 5. 21. Signature of Funeral Service Licens LICENSED HORTICIAN ZANNINO CHARLES anners BALLIMONE, MD 21237 1915 ELLINWOOD ROAD 23a. Part1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line: Approximata Intarval Batween Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical MYOCARDIAL INTARCTION DAYS Examiner Examiner physicien and the burial-transit Sequentially list conditions, if sny, leeding to immediata cause. Enter Underlying Cause (Diseasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hortic 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Was an eutopsy performed? 1 Yas 2 No 1 Yas 20 No Division of Vital 25. Was cesa rafarred to medical examinar? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending Investigation Hospital or Attending 1 Neturel n 24 hours after death.

Funeral Director: After determine the function of the 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28a. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 18 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29e. Cartifiar edicai To the Hosp within 24 hos To the Fune completely fi (Check only one) 29b. Signatura and tillayof certifiar 29c. Licensa number 29d. Date signed (Month, Day, Year) D-40525 ss of person who completed causa of death (Item 23a) (Type, Print) Rudolph North BROADWAY BAlto . Md. 21231 TITANI 100 31. Data filed (AP) 37 Degistrar's Signature State Registrar

& DHM



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Exam	iner	4e. Facility Nama (If not instituti Genesis Eldero		mbar)			4b. City, Town, Severna	or Location of Dea Park		of Death e Arur	ndel
¿Funera Directo	_	5. Sociel Security Number 140–12–5877	6. Sex 1 Ø M 2 ☐ F	7. Aga (In yrs. 75		If Under 1 Yaar Months Days		fin. A Deta of B	irth 20, 1923	9. Birthpla New	ce (State or Foreign Jersey
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pemit. Pages 1 er Department of Hea Important: If Item; any Injury or other		4 Donation 5 Other (Specify)	Stata	cro Cre	matory I Name and Addra allings	nc. Iss of Facility Funeral	7/13/99 Home PA Pasadena			ryland
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that the death certific led by the attending p detached for use as	y Physician/Me	Pert II. Other significant conditions and the conditions are the condi				darlying cause giv	van in Part I.		tobacco use cor		ne cause of death
aw requires is been sign 2 should be	Completed by	Dely dro Cornary	Ateny	Din	are			perfe	an sutopsy ormed?	avails comp of dea	
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To the Hospital within 24 hours of To the Funeral Completely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, deta end piece, end dua to the cause(s) end mennar as stated. 2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, deta end piece, and dua to the cause(s) and mennar stated.									e cause(s)
Tot with Tot	Σ	29b. Signatura and litla of certified by Chymole 30. Nama and address of person	MO ACC	weing	Docta	29c. Licans	a number	-4 10ENA,	29d. Dete signed	(Month, Day	999
31.5		C.V. CYRIAC.	who completed caus	a of death (Item	23a) (Type, P	rint)	PASI	ADENA,	אוג עש	22	
Sta Regist		31. Data filed (Month, Day, Year)	1999	gistrer's Signati	ura \mathcal{G} .	Spork					

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death Month 1. Decedent's Nama (First, Middle, Last) 3. Time of Death **Physician** 20:49 99 4a Facility Nama (If not Institution, give street and number) VY DIN /Medical 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE MD.

If Undar 24 Hrs. 8. Days of Birth
Hours Min. (Month, Day, Year) N/A 5. Social Sacurity Number 6. Sax Center If Under 1 Year 7. Aga (In yrs. last birthdey) Birthplaca (State or Foreign Country) Sax 1 M 2 ☐ F **Funeral** Days Months 51 Yrs. 219-50-4532 Director JUN 2, 1948 MARYLAND Usual Rasidance of Dacedant the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show Was 2 No Director MARYLAND BALTIMORE CITY N/A 10g. Citizan of What Country? 10e Street and Number 10f. Zlp Coda with r than "natural", or items 23s or the Medical Examiner must be: 733 CARROLL STREET 21230 U.S.A. death v Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forcas? 11. Marital Status filed within 72 hours after 1 Nevar Married 2 Married 1 ☐ Yes 2 ☐ KM 1 ☐ Yas 2XXNo Specify: Maryland 21215-0020 Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) BALTIMORE CONVENTION OPERATION CREW LEADER CENTER unknown other 1 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be in nent of Health and Mentel Int: If item 27 is marked or GEORGE TURPIN, III VERA MOORE 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacquelyn L. Turpin/Wife 733 Carroll STreet, Baltimore, Maryland 21230 other 1 altimore. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Mathod of Disposition Data cemetery, cremetory or other place) 1 ☐ Burial 2 ☐XO(emation 3 ☐ Removal from Stata 6 permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) 7-12-99 BALTIMORE, MARYLAND METRO CREMATORY 21. Signature of Funaral Sarvice Licensee 22. Name and Addrass of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA arbara 2000 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, laading to immediate causa. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last and bunial-tran Due to (or as a consequence of) Box 68760. physician Physician/Medical the Dua to (or as a consequence of): 80 980 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by I 1 Yes 2 No 3 Probably 4 Unknown Hyperension Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed Seizere Disonper. has paga 2 HIVE 1 □ Yas 2 No 1 Yes certificata Division of Vital 25. Was casa referred to medical axaminar? or Attending Physician: funeral director, 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 0 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? Certification: 27. Mangar of Death 28a. Data of Injury (Month, Dey Year) 28b. Tima of 28d. Describe how Injury occurred After 1 Natural 2 Accident 5 Panding after deeth. Director: Aft 1 Yas 2 No invastigation 6 Could not be datarmined 3 Suicida 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) filled in by 4 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

Medical Exampinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Cartifier Medical completaly (Check only one) and mannar stated. within 2 To the \$ Artending Emergery 29d. Data signed (Month, Dey, Year) 29b. Signatu 29c. Licensa number

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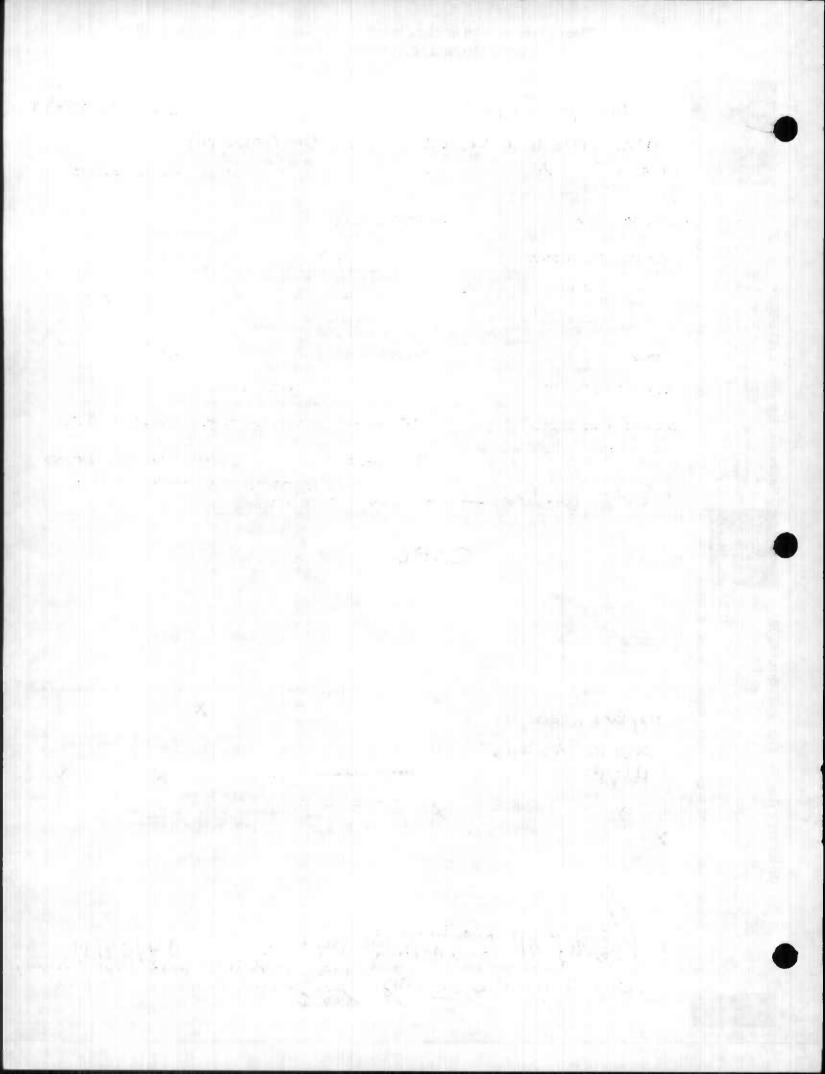
32. Registatis State

s of person who completed cause of death (Itam 23a) (Type, Print)

1999

mercy medical Cerrers

State Registrar



SP AMEN	ID: ITEMS: #23 PART 1. Decedent's Name (First, Middle	1, 27, 28A-1	PER MEL	6//9/01	incate of	Death	2. Date of De	Reg. No. ath	3. Tima of Death		
Physician	Fred Doug	las Tipt	Month JULY								
/Medical Examiner	4a Facility Name (If not institution CARROLL COUNT			+		4b. City, Town, or WESTMIN		4c. County of Dea	th		
irector	5. Social Security Number 6. Sex 10 M 20 F 36 Yrs. Social Security Number 217-86-1776 10 M 20 F 36 Yrs. Social Security Number 10 Months 10 Days 10 Months 10 Days 10 Months 10 Days 10 Months 10 Days 10 Months 10 Days 10 Months 10 Days 10 Months 10 Days 10 Months 10 Days 10 Months 10 Days 10 Months 10 Days 10 DeC • 15 9 1							1 Year) 1962 M	thplace (State or Foreignal)		
	Usual Residence of Decedent 10a, State 10b, County		10c Cit	v Town or Lo	cation				10d. Inside City Limit		
Wert sho	Maryland Carroll Finksburg								1 Yes 2 W		
	10e. Street and Number 2709 Chippewa Ct. 10f. Zip Code 21048 U.S.A.										
by	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nollit Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 15. Specify: White										
oted eted	15. Deceden			16a. Deced	lent's Usual Occi	upation a during most of wo	rking	16b. Kind of Business/Industry			
nt, the Wedge Completed	Elementary/Secondery (0-12)		ducellon ade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Concrete foreman						Gray & Son		
tic avent.	17. Falher's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sur Virginia Railey										
traums	19a. Informant's Name/Relations		other					er, City or Town, State, 312. We			
nt: If itam ; nry or other	Jerry M. Tipton - brother 76 Pennsylvania Ave. Apt. 312, Westminst 20a. Method of Disposition Date 20c. Location - City or Town, State										
Importa any Inje page.	21. Signature of Funeral Service	Licensee	6	EC 3.2	Name and Add khardt 96 Cha	Funeral	Chape	l ester. Md	. 21102		

Physician /Medical Examiner

> Be Completed by Physician/Medical Examiner Medical Certification: To

sate hes been signed by the attending physician and page 2 should be detached for use as the burial-transit

To the Hospital or Attanding Physician: The lew requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Immediate Cause (Final disease or condition resulting in deeth)

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last

BLUNT FORCE INJURIES OF THE HEAD Due to (or es a consequence of): Due to (or as a consequence of):

Due to (or as a consequence of):

Part II	Description of the significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Ware eutopsy findings available prior to completion of cause of death?

26. Place of Deeth (Check only one)

JULY

07,1999

25. Wes case referred to medicel				26. Place of De	eth (Check only	one)	
examiner? 15© Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	30 DOA	Other: 4 Nursing	Home 5 Res	sidence 8 [☐Other (Specify
27. Menner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		Injury at	28d. Describe		
1 Natural 5 Pending investigation		6.49	М	1 Yes 2 No	SUBJECT	STRUCK	ON THE HE

AD 8 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 M Homicide

(IN VEHICLE) CARROLL COUNTY, MARYLAND 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number

O.C.M.E

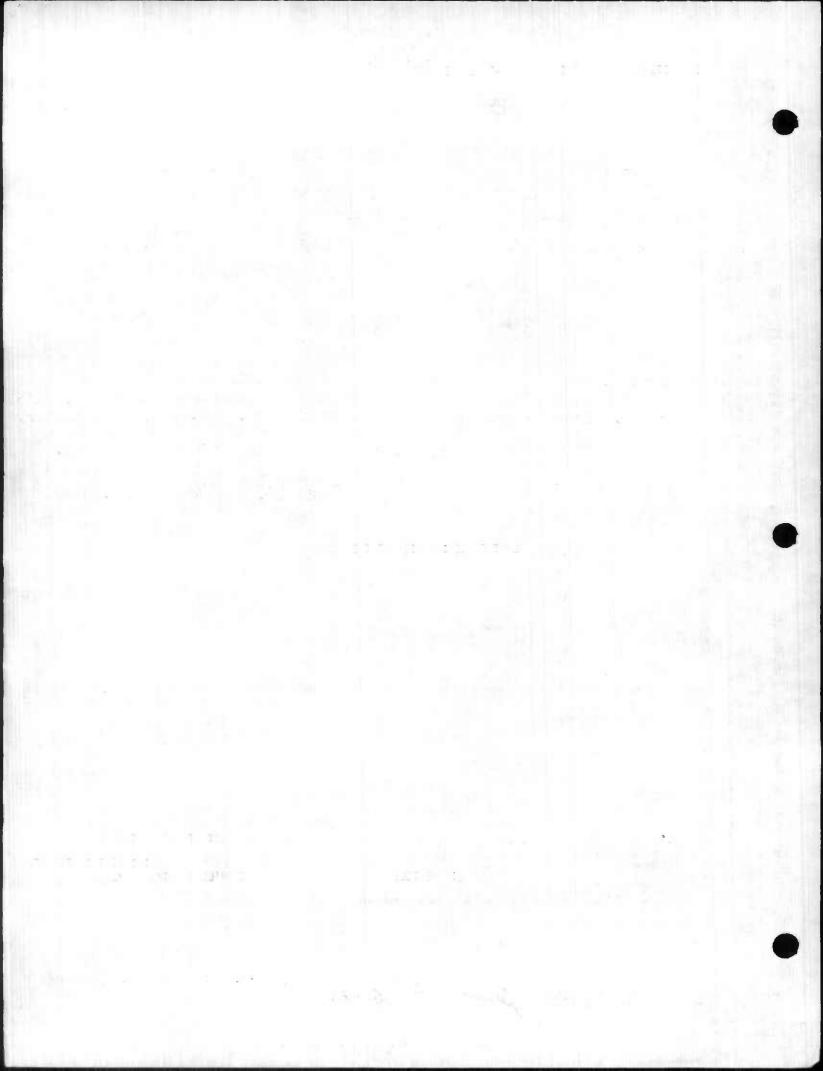
30. Name and address of paragony ipleted ceuse of death (Item 23e) (Type, Print)

111 Pen S Baltimore, Maryland 21201

State Registrar te, ho 35 Register & Signature 9.

within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

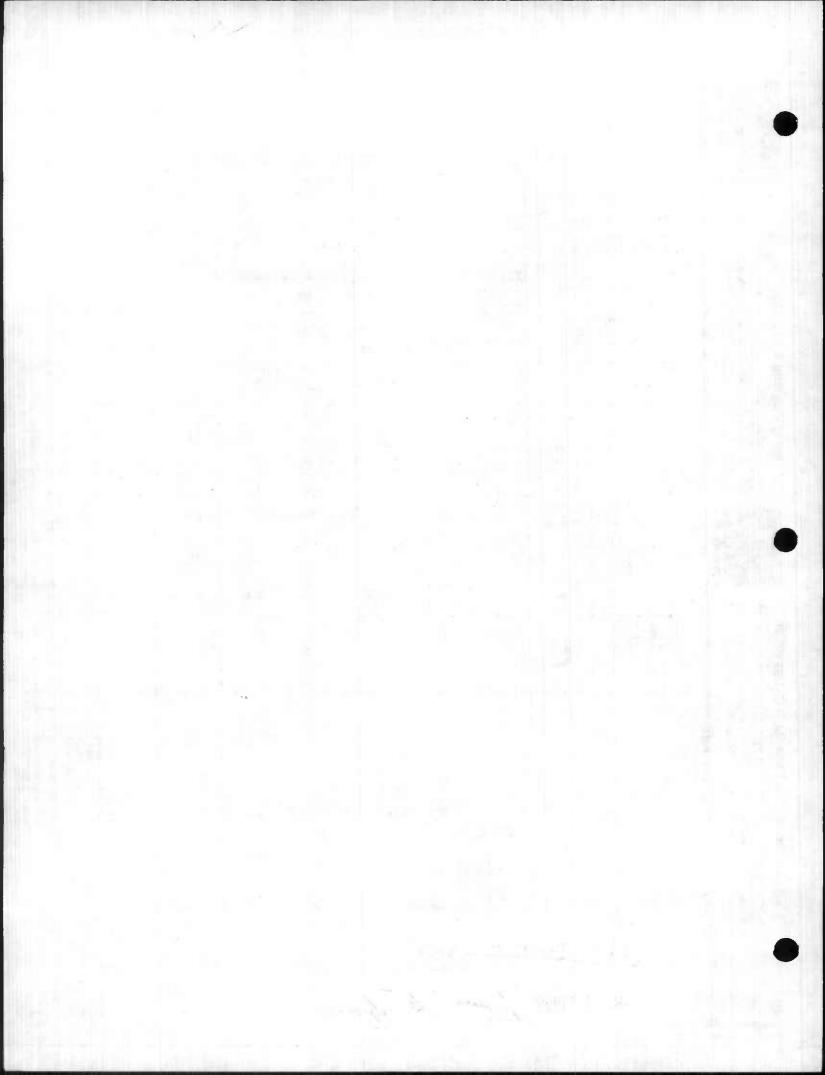


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State of Maryland / Department of Health and Mental Hygiene 99 2 1 7 9 0

			Certific	cate of	Death	R	eg. No.	ed (m	1120		
	Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Dey										
ANNA	ANNA VEIT								9:05 AM		
4a Facility Name (If not instituti	on, give street and number	r)			4b. City, Town, or L	ocation of Deeth	4c. County	of Deeth			
MILLENNIUM HEALTH & REHABILITATION GLEN BURNIE ANNE AR											
5. Social Security Number 212-05-9469	6. Sex 1 □ M 2 💢 F	oge (In yrs. lasi 94		Inder 1 Yearnths Days		8. Dete of Birth (Month, Day, JAN . 17			ece (State or Foreign ry) 'LAND		
Usual Residence of Decedent 10a. Stete 10b. Count		100 Ch. T	own or Location					Lan			
		Toc. City, 1						10	od. Inside City Limits 1 ☐ Yes 2 ☑ No		
MARYLAND ANN	E ARUNDEL		GLEN B								
10e. Street and Number 423 CRAIN HIGH	WAY, S.E.,	APT. 20		V. Zip Code 2106	51		0g. Citizen of V U • i	What Count S.A.	ry?		
11. Meritel Stetus 1 Never Merried 2 Me 3 Meritel Stetus 1 Never Merried 2 Me 3 Meritel Stetus 15. Decede (Specify only high Elementary/Secondary (0-12)	Armed Forces? If Yes, sp. Merried 2 Merried 1 Yes 2 No					peedent of Hispanic Origin? (Specify Yes or No- specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Arr Bleck, Whose Specify: Specify:					
	est grade completed)	1	6a. Decedent's	Uaual Occu	pation a during most of wor	kina	16b. Kind of Bu	usiness/Ind	ustry		
Elementary/Secondary (0-12)		r 5+)			e during most of worked)						
8			HOMEMA	KER			OWN	HOME			
17. Father's Neme (First, Middle	e, Last)					ne (First, Middle, I					
(UNKNOWN)			HARD	EN	LUCY			FOSTE	X		
19a. Informent's Neme/Reletion					at and Number or Ru						
KATHY M. HERMA	N (GRANDDA				WOOD ROAD,	DENTON,	MARYL	AND 2	1629		
20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion	3 DRemovel from Stat	com	e of Disposition etery, cremetor		ece)	Dete	20c. Location -	City or Tov	vn, State		
4 Donation 5 Other			OWRIDGE	MEMOR	RIAL PARK	7/10/99	ELKRI:	DGE,	MD.		
21. Signature of Funeral Service	e Licensee	7-3	22. Nan	ne and Addr	ress of Fecility SI	NGLETON	FUNERA1	HOM	E, P.A.,		
) MX	20/000		1 S	ECOND	AVENUE, S	.W., GLE	N BURN	IE, MD	. 21061		
23a. Part1 Enter the disease shock, or heart failure. Lis	or complications that caus	ed the death. I	Do not enter the	mode of dy	ring, such as cardiac	or respiretory erro	est,	-	Approximate		
shock, or heart failure. Lis	st only one cause on each	line.							Interval Between Onset and Deeth		
Immediate Cause (Finel	Co	ronary	Arter	y Di	sease			9	years		
disease or condition resulting in death)	8							1	-		
	Po		a consequenc		aion			1	2		
	b		1 Нуре	-	STOIL			- 1	3 years		
Sequentially list conditions, if eny, leeding to immediate	Par		n's Di		0			17	years		
Cause (Disease or Injury	c	LKINSO	11 5 01	seas	_			- /	years		
that initieted events resulting in death) Last		Due to (or as	e consequence	of):							
	d										
							73	1			
Pert II. Other significant condit	ions contributing to death	but not resultin	g in the underly	ring cause g	iven in Pert I.	23b. Did to	bacco usa co	ntributa to	the cause of death?		
						1 □ Y	os 20 No	3 Prob	ebly 4 Unknown		
								0.45			
						24a. Wes e perform	n autopsy ned?	eva	re autopsy findings illable prior to		
								of d	npletion of ceuse leath?		
						1 🗆 Ye	s ZE No	1□	Yes 2□ No		
25. Wes case referred to medic	al				26. Place of Des	th (Check only on	e)	1			
examiner? 1 ☐ Yes 2 ☑ No	Hospital:	tient 2□ER	/Outpatient 3[DOA O	ther: 45 Nursing H	ome 5 Reside	nce 6 Oth	er (Specify)		
27. Manner of Death	28a. Dete of tre (Month, E		b. Time of	28c. Inje		28d. Describe ho					
1 Netural 5 Pend 2 Accident inves	ing (Month, L tigation	lay Year)	Injury M		ork? ☐Yes 2☐No						
3 Suicide 6 Couk 4 Homicide		28f. Location (Street end Number or Rural Roule Number, City or Town, State)									
29a. Certifier (Check only 2 Medica	ing Physician: To the besi Examiner: On the basis and manner:	of examination	dge, death occu and/or investig	erred et the tation, in my	time, date and place opinion, deeth occu	, and due to the corred at the time, d	ause(s) and ma ate end place,	anner as sta and due to	ated. the cause(s)		
29b. Signaftee and tiple of certific				29c. Licer	nse number		9d. Dete signe				
· Dan	Admeh				D14160		07/08/				
Tivo	Juan 8.	- MY)								
30. Name and eddress of person											
Harjit Si		5410-	A Rito	hie	Highway	Baltimo	ore, M	d. 2	1225		
31. Date filed (Mont) Day, Tea	2 1999 32. Regis	trar's Signature	19	(no 11	,						

DHMH 16 Ray 6/95



Please Type or Print in Biack indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year Wilson Rosetta July 4 4b. City, Town, or Location of Death Joan 4 1999 6:55am 4e Facility Neme (If not institution, give street and number) 4c. County of Death Baltimore Sinai Hospital H Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) July 16 45 5. Social Security Number 7 Age (In vrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) M • D • Deys 1 M 2DXF Months 54 219-40-6663 10a Stete 10b County 10c. City. Town or Location 10d. Inside City Limits 1 N Yes 2 No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21215 5022 Palmer Ave 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Detes: 14. Race - American Indian, Bleck, White, etc. 11 Merital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th grade 17. Father's Neme (First, Middle, Last) Housewife Home na 18. Mother's Name (First, Middle, Maiden Sumeme) Alice Starkes Harmon Spence 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 5022 Palmer Ave, Baltimore Md Calvin T. Wilson-Husband 20a. Method of Dispestion 1 Burial Cremetion 3 Removel from Stete 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 7/10/99 Randallstown, King Memorial Park 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Neme end Address of Facility March F/H West 23a. Pert1. Enter the disease, or complications that caused the doubt. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart eliure. List only one cause on each line. 21215 Baltimore Md Approximete Intervel Betw Onset and Death Immediate Cause (Finel disease or condition resulting in deeth) deseare Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or as consequence of): de Due to (or es a cons equence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24e. Was en autopsy performed? 24b. Were autopsy findings available prior to of cause 1 Yes 2 THO 1 Yes 2□ No 25. Was case referred to medical 26. Place of Deeth (Check only one) exeminer? 1 2 Yes 2 □ No Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 ER/Outpatient 3□ DOA 28a. Dete of Injury (Month, Day Year) 27. Manne of Death 28d. Describe how injury occurred 28b. Time of

Examiner Box 68760.

Physician

/Medical

Examiner

Funeral

Director

28a-f show must be notified at

6

Hygiene.

Peges 1 and 2 should be in nent of Health end Mental I wit: If item 27 is marked of

of Health of Itam 27 i

other

ortant: If it Department of important: If any injury or

Physician

/Medical

Director

Funeral

by

Completed

Be

the Meryland

filed within 72 hours efter

21215-0020

Baltimore, Maryland

Examiner Physician/Medical ģ Completed certificate has Be this

funeral director. Certification: To After the

filled in by

edical

The law requires that the death certificate be executed

Division of Vital Records, P.O. Attanding Physician: To the Hospital or Attandil within 24 hours after death. To the Funeral Director: A

State Registrar

DHMH 16 Rev 6/95

Dey, Year)

1 Netural

2 Accident

3 Suicide

29e. Certifier

4 Homicide

(Check only one)

29b. Signeture and Title of certifier

12 1999

5 Pending

investigetion

6 Could not be

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29c. License number D38041

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) end menner steted.

28c. Injury at Work?

11 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner as stated.

1 ☐ Yes 2 ☐ No

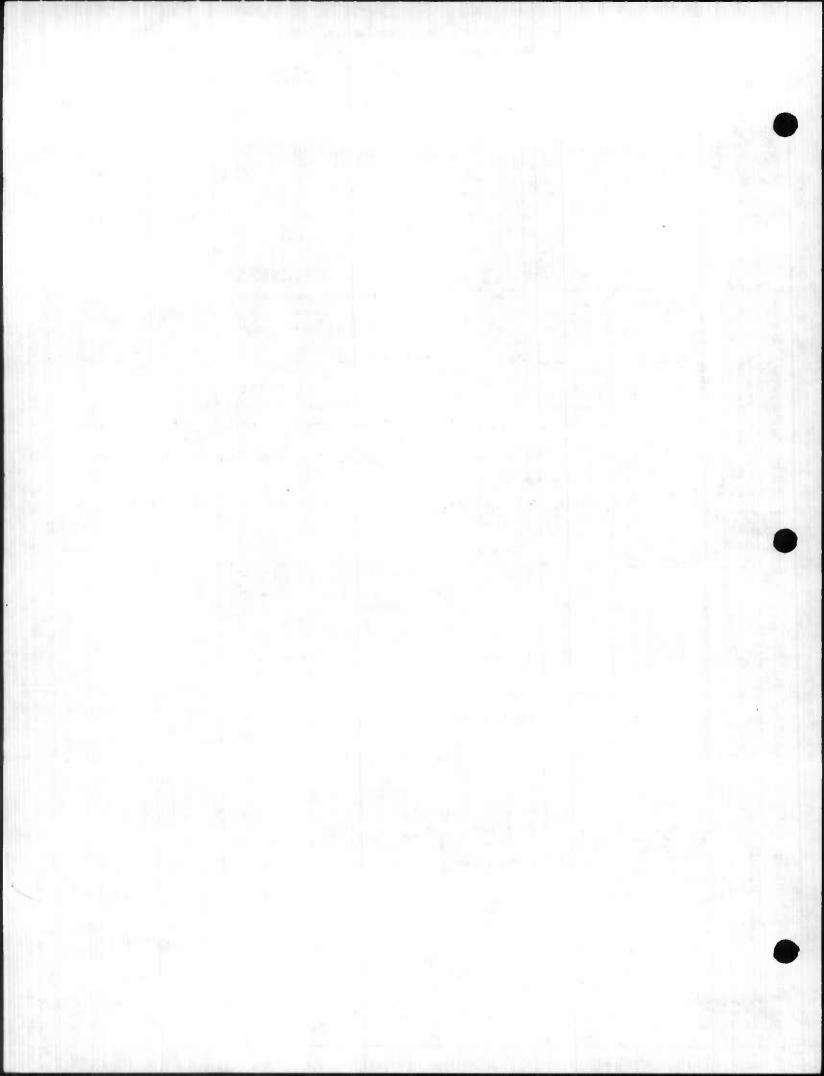
nroads #100

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Neme and address of person who completed cause of death (Item 22a) (Type, Print) 400

32. Registrer's Signeture

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death 1422 0" homas Facility Name (If not institution, give street and number 4b. City, Town, or Location of De 4c. County of De Baltimore (City Baltimore Social Security Number lano If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1/1 M 2□ F 7. Age (In yrs last birthday) If Under Birthplace (State or Foreign Country) Months Days 283-44-8515 8. Ohio Usual Residence of Decedent 10b. County 10c City Town or Location 10d. Inside City Limits N/A 1D Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1238 Cleveland Street 21230 USA 12. Was Decedent Ever in U,S. Agned Forces? 1 ⚠ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harvey James Wilt Amelia Alice Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Brown 1238 Cleveland St., Baltimore, MD 21230 20a. Method of Disposition 1 Deurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State HD Veterans Cemetery 7/12/1999 Crownsville 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Signature of Euroffith Service Licensee 3111 Mountain Rd., Pasadena, MD 21122 hat coused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, on each line. 23a. Part1 Enter the disease shock, or heart failure. Interval Between Onset and Death two Immediate Cause (Final ess than hour Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part t. 23b. Did tobacco use contribute to the cause of death? 35 Probably 4 Unknown 1 Yes 2 No 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 26. Place of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

à

Completed

10a, Stata

Funeral

Director

7 is marked other than "natural", or Itema 23s or 28s-f ahow treumatic avent, the Madical Examinar must be notified at

parmit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiena.
Important: if flem 27 is marked other than "natural", or flems 28a each Injury or other treumatic avent, the Medical

Baitimore, Maryland 21215-0020

Maryland

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physicien and the buriel-transit 8 signed t page 2 s after death. i Director: Aft of in by the fur

The lew requires that the death certificate be axecuted

Records, P.O. Box 68760,

of Vital

Division

or Attending Physician:

After this

24 hours Funeral

To the Han within 2: to To the Functional

Physician/Medical Examiner 2 Completed 8 Certification: To 27. Manner of Death

25. Was case referred to medical

1 Yes 2 No 5 Pending investigation

1 Inpatient 28a. Date of Injury (Month, Dey Year)

6 ☐ Could not be 28e. Plece of tnjury - At home, farm, street, factory, office building, etc. (Specify)

2 A ER/Outpatient 3 DOA

28b. Time of Injury

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Naturat

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of gertifier

30. Name and address of person who completed sause of death (Item 23a) (Type, Print)

29c. License number

29d Date signed (Month, Day, Year)

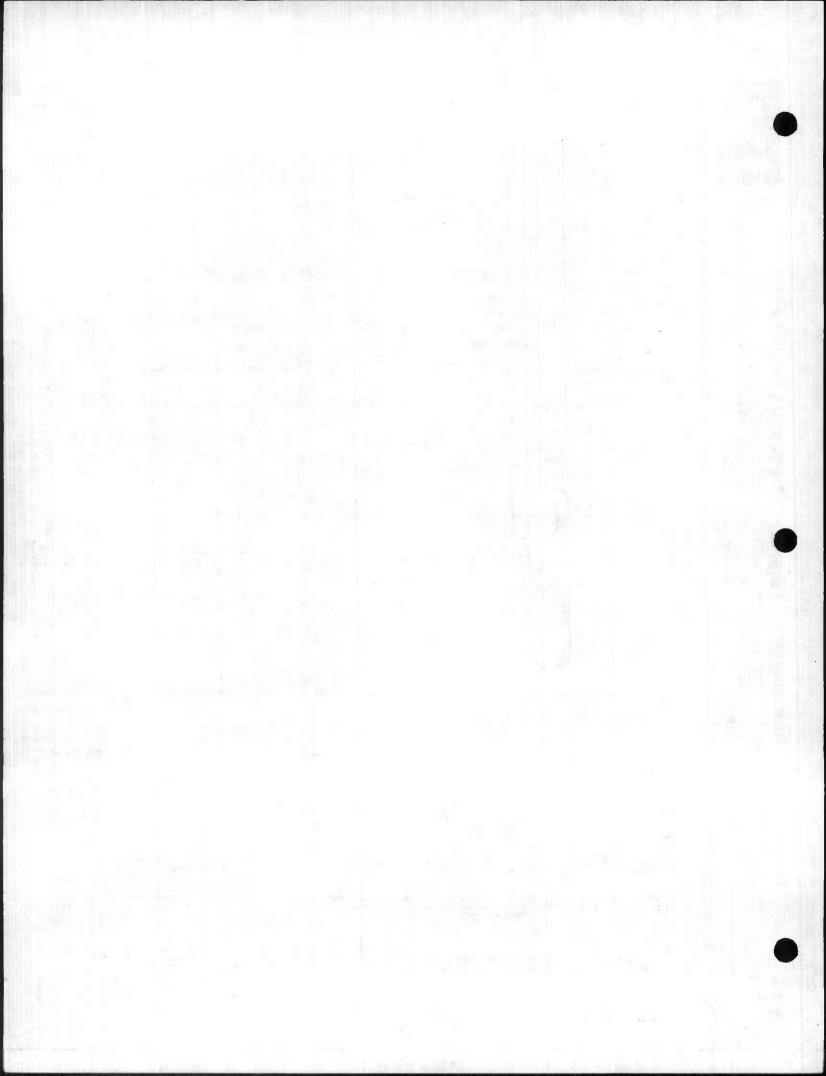
State Registrar

Medical

31. Date filed (Month, Day, Year) JUL 1.2 1999 32. Registrar's Signature

souks

DHMH 16 Rev 6/95



99-3881-510

Physician

/Medical

Piease Type or Print in Biack indelibie ink. Assure Aii Copies Are Legibie.

ALLEN WHITE HEAD ITEMS: #23 PART I, 27, 28A-F PER MEI G773 Certificate of Death

ALLEN BERNARD WHITEHEAD

4e Facility Name (If not institution, giva street and number)

1. Decedent'a Name (First, Middle, Last)

State of Maryland (Department	of Health and Mental I	Hygie
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e	0	9	0.1		0	0
o.	2	2	21	- /	9	5

3. Tima of Death

11:35A.M.

Reg. N

Dev

06,1999

4c. County of Death

2. Date of Death

Month

JULY

4b. City, Town, or Location of Death

	D	ireci
Baltimore, Maryland 21215-0020	nemit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland additional Manual Hedisons.	reportant: If Item 27 is marked other than "natural", or items 23e or 28e-1 show my injury or other traumatic event, the Medical Examiner must be notified at

Funeral Days Hours Months 51 Yrs. 212-46-2445 tor Usual Residence of Decedent 10a Stata 10c. City, Town or Location 10b. County Md. N/A Director Baltimore City 10e. Street and Number 10f. Zip Code 1028 N. Stockton Street Funeral 21217 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Merried 1 Yes 2 No Specify: 3 ☐ Widowed 4 Ď Divorced g Yeer or Detes Completed 16a. Decedent'a Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grads completed) Elementery/Secondary (0-12) Collega (1-4or 5+) Nursing 12th 17. Fathar's Neme (First, Middle, Last) Be Nathaniel Whitehead Alice Edwards 19e. Informant'a Neme/Reletionahip (Type, Print) Alice Parker/Mother 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 1 X Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata Mt. Zion Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Juneral Service License Elm **Physician** /Medical Immediate Ceuse (Finel ACUTE ETHANOL AND NARCOTIC INTOXICATION diseesa or condition resulting in death) Examiner Due to (or es a consequence of) Examiner the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Diseese or injury that Initieted avents rasulting in death) Last burial-tran pue Due to (or as a consequence of) physician the burial Box 68760. Physician/Medical Dua to (or as e consequence of) USB Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. signed t Records, þ should Be Completed ate has Division of Vital Attending Physician: 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2004 FR/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28e. Dete of Injury Our (Month, Day Year) 7-6-99 27. Menner of Deeth 28b. Time of A 28c. Injury at Work? After Fourty 10:15 1 Netural 5 Pending UNKNOWN death. 1 Yes 2 No Invastigation 2 Accident or Attendation of Director: 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
FOUND IN HOUSE n 24 hours after ne Funeral Directions of Filled in b 4 Homicide Hospital 29a. Certifier Medical (Check only one)

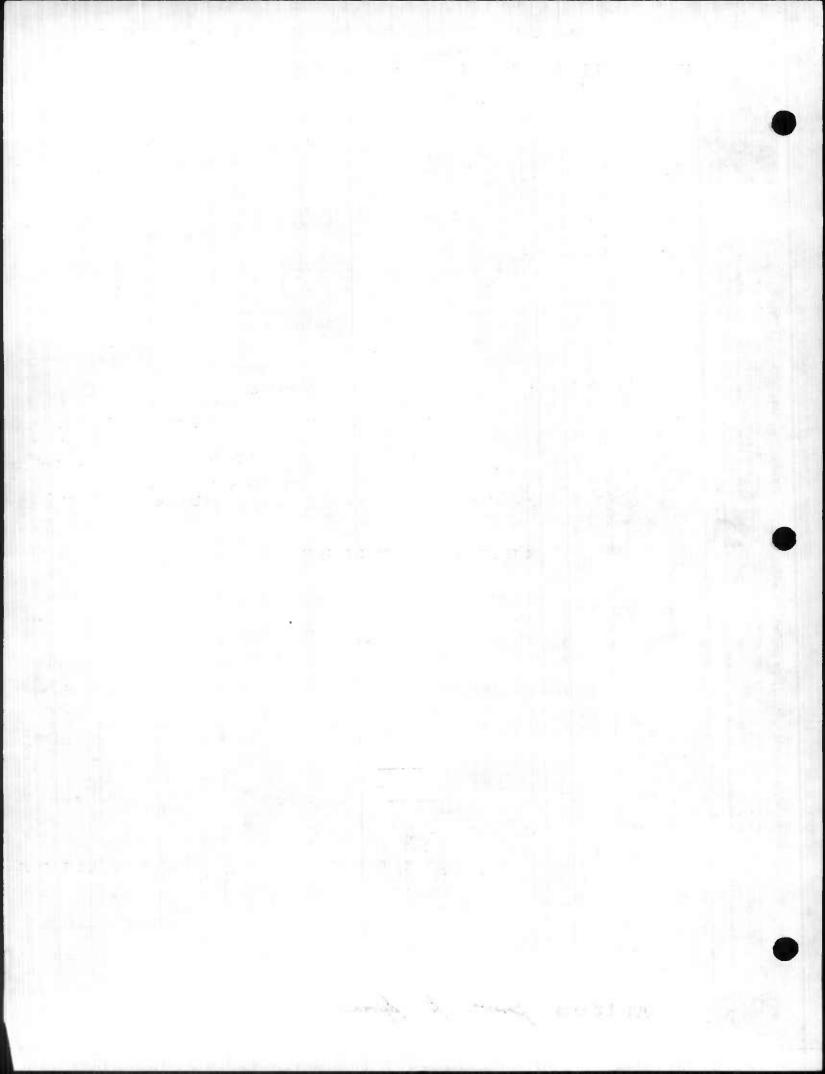
MERCY MEDICAL CENTER BALTIMORE If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sax x M 2 F 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Maryland 10d. Inside City Limita XYes 2□No 10g. Citizen of What Country? U.S.A. Race - American Indien, Bleck, White, etc. Specify: Black 16b. Kind of Business/Industry Private Duty 18. Mother's Name (First Middle Meiden Sumeme) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1028 N. Stockton Street, Baltimore, Maryland 21217 20c. Location - City or Town, State 7/10/99 Landsdowne, Maryland 22 Name and Address of Facility
William C. Brown Community Funeral Home 1206 W. North Avenue, Baltimore, Md. 21217 23a. Pen1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably Dunknown 24b. Were autopsy findinga aveilable prior to 24a. Waa an autopsy performed? completion of cause of death? yes 2 No 121es 2□ No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1210 N. CALVERT STREET BALTIMORE, MARYLAND 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. To the Hosp within 24 ho To the Fune completely fi 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) lucker O.C.M.E. JULY 7,1999 Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) Dennis J. Chuteno

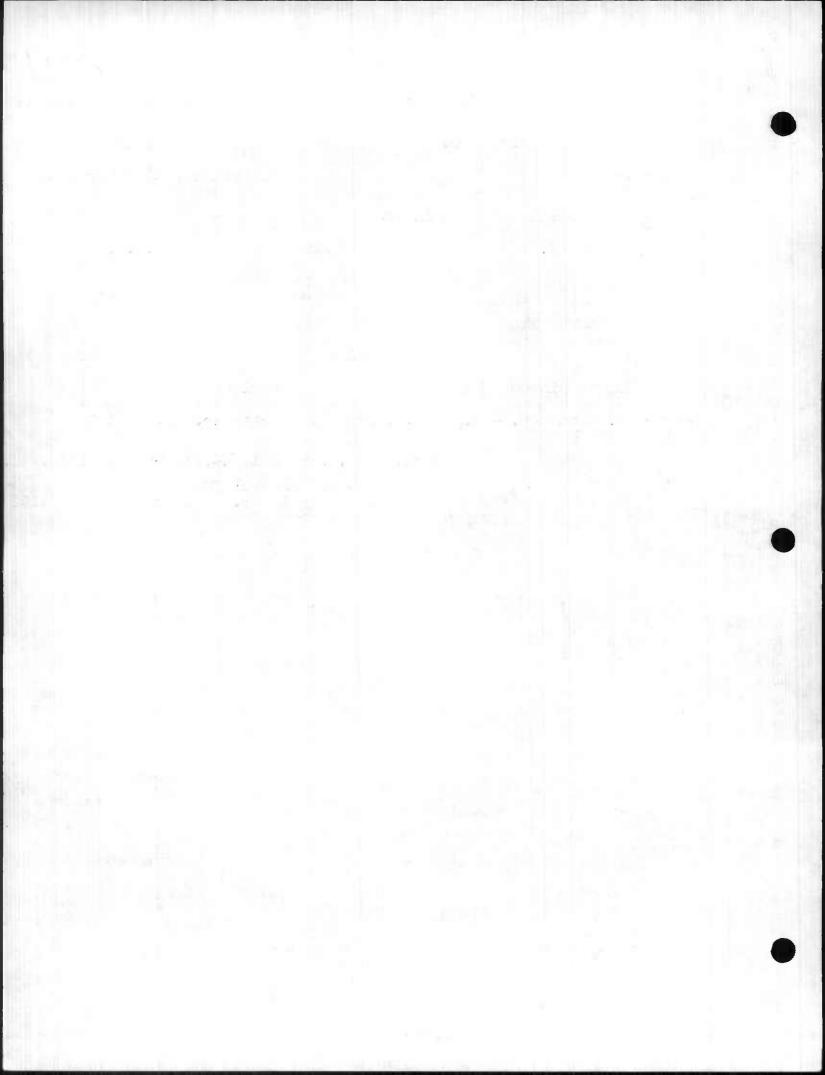
State Registrar 31. Data filed (Month, Dev. Year)
JUL 12 1999

32. Registrer's Signeture

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Replacement Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Day 999 Yaar July **Physician** 8, 12:15 pm Thelma J. Watts /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Long View Nursing Manchester Ca
r If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Dey, Year) Home Carroll If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Deys Months 1 M 2 F 82 Director 219-30-0331 April 26. 1917 Maryland Usuei Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23s or 28s-f show solical Examiner must be notified at Md Carroll Millers 1 ☐ Yas 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4153 Rupp Rd. 21102 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Reca - American Indian 11. Meritel Stetus Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after of or of Health and Mental Hygiene.
Int. If item 27 is marked other than "natural", or item into or other traumatic event, me incline the natural into or other traumatic event, me incline. 1 □ Never Married 2 □ Married Baltimore. Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White by 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Housewife Homemaker 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Ernest Linwood Bell Henrietta Gertrude Wain 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Howard F. Watts Jr. - son P.O. Box 70, Manchester, Md. 20b. Plece of Disposition (Name of cemetery, cremetery or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removel from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) Lakeview Mem. Park July 10, 1999 Sykesville, Md. 22. Name and Address of Facility
Eckhardt Funeral Chapel 21. Signeture of Funeral Service Licenses inau 3296 Charmil Dr. Manchester, Md. 21102 23a. Part Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, above, of heart feilure. List only one cause on each line. Approximete Intarval Between Onset and Death **Physician** /Medical Immediete Causa (Final disease or condition resulting in death) Vacculus 220 Examiner Due to (or es e consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that infliated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 080 P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records. þ 24b. Wera autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? Completed 1 Yes 2 No 1 Yes 2 HN6 Division of Vital or Attending Physician: 25. Was casa referred to medicel axaminer? Be 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Manner of Death 28d Describe how Injury occurred 28b Time of 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 1- Neturel 5 Panding 1 Yes 2 No death. Investigation 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide filled in Hospital edical 29e. Certifier 🛨 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mannar as stated. To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, dete and plece, and due to the cause(s) end menner steted. (Check only one) 29b. Signature No of dentifier 29c. License number 29d. Dete signed (Month, Day, Year) 19 33165 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) 2111 Hansver like 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State JUL 23 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Data of Deeth 3. Time of Death Month Year Mary White 9:00 P.M. July 6 1999 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth North Arundel Hospital Glen Burnie Anne Arundel If Under 24 Hrs. Hours Min. 5. Social Security Number 6 Sex 7. Aga (In yrs. last birthday) If Under 1 Year 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) Days 1 M 280 F Months 220 12 5054 85 Nov. 13, 1913 Maryland Uaual Rasidence of Decedant 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Maryland Anne Arundel Pasadena 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code 21122 444 Magothy Bridge Road U.S. 12. Waa Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yea, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, 11. Maritel Status Black, Whita, atc 1 Yes 2 XNo
If Yas, Giva
Yeer or Datas: 1 Nevar Married 2 Merried 1 Yas 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Service Machines 8th Vendina 18. Mothar's Nama (First, Middle, Maiden Sumame) 17. Fathar's Name (First, Middle, Last) Mary Kraft Charles E. Myers 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e. Informent's Neme/Ralationship (Type, Print) Joan Heffner / Daughter 444 Magothy Bridge Road Pasadena, Maryland 21122 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Ramoval trom State 7/9/99 Baltimore, Maryland 5 ☐ Othar (Specify) Loudon Park Cemetery 4 Donation 21. Signature of Funare Sarvice Licensee 22. Nama and Addrass of Facility

Physician /Medical Examine

Physician

/Medical

Examiner

10e State

Director

Funeral

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Completed

Be

Funeral

Director

28a-f

than "natural", or hams 23s or the Medical Examiner must be.

Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked oth any Injury or other traumetic event.

Baltimore, Maryland 21215-0020

Box 68760.

Records. P.O.

Division of Vital

ve Hospital or Attending P n 24 hours after death. ve Funeral Director: After t

within 2

After t

Examiner ician and burial-transit Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Disease or injury that initiated events rasulting in death) Last attending physician for use as the buria Physician/Medical

ò

Completed

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10

Certification:

Immediete Causa (Final disaasa or condition resulting in death)

23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or hear tailure. List only one cause on each line.

4001 Ritchie Highway

Approximete Intarval Between Onset and Death

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.

Torrel

Steptructure Umare ougetwe

Dua to (or as a consequence of)

23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yea 2 No

Gonce Funeral Home P.A.

Baltimore, Md. 21225

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

2 No

1 Yas 2 No

25. Was casa ratarred to medical axaminar? 1 Yas 2 No

27. Mennar of Death

1 Natural 2 Accident

3 ☐ Suicida

4 - Homicida

Hospital: 1 ☐ Inpatiant 28e. Dete of Injury (Month, Dey Year) 5 Panding Invastigation

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work?

Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 28d. Describe how injury occurred

1 Tas 2 No

26. Place of Death (Check only one)

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 29a. Cartifia (Check only one)

1 X Certifying Phyatcian: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

28t. Location (Street and Number or Rural Route Number, City or Town, Stata)

29b. Signatura and title of cartifier

6 Could not be datamined

29c. License number

29d. Data signed (Month, Day, Year)

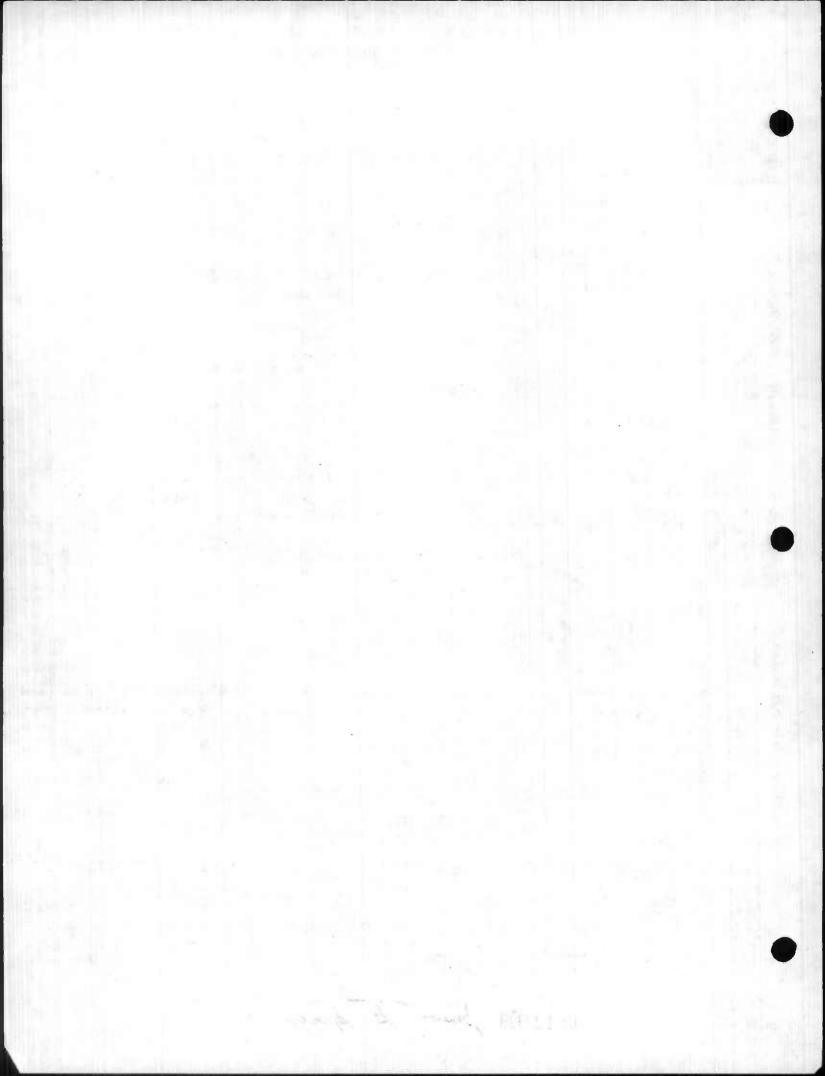
Attending Doctor . Nama and address of person who completed cause of death (Norn 23a) (Type, Print)

8-109 RITCHER LOWT N. CYRIAC, M.D

State Registrar

32. Registrar's Signatura 31. Data filed (Month, Day, Year)

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day SALENA AVIRETT SARAH JUNE 28 1999 06:45AM 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY tf Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) JUNE II 1918 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) Months Days 1□M 2√2F 81 Yrs W. VA. 214-05-7422 Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyas 2 No MARYLAND ALLEGANY CUMBERLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 740 WASHINGTON STREET 21502 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, atc. Was Decedent Ever in U,S. Armed Forcas? 11 Marital Status 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2 🖔 No If Yas, Giva Yaar or Datas: 1 Yas 2 No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry

HOME MAKER

21502

Approximata Interval Between Onset and Death

24 HOYRS

36 HOURS

1 MONTH

1 Yas 2 No

MARYLAND

29d. Data signed (Month, Day, Year)

JUNE 28, 1999

18. Mother's Name (First, Middle, Maiden Sumeme)

OKIE VEIRING

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code)

with the Maryland r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at death permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If frem 27 is marked other than any injury or other traument.

Physician

/Medical

Examiner

10a. Sfate

Elementary/Secondary (0-12)

JOHN E. SHARP

17. Fathar's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

12 + College (1-4or 5+)

Director

Funeral

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Completed

Be

Funeral

Director

Physician /Medical Examiner

siclan and burial-transit

physician s the burial

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The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records.

or Attending Physician:

Hospital

To the

this funeral

Affer

r death.

24 hours after deat Funeral Director:

within 24 hor To the Fune completely fi

filled in by

29a. Certifiar

(Check only onel

29b. Signature and fifle of certifian

Examiner Physician/Medicai þ Completed Be Medical Certification: To

JAMES ALFRED AVIRETT HUSBAND 740 WASHINGTON STREET CUMBERLAND MARYLAND 20b. Plece of Disposition (Nema of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 Donation 5 NOther (Specify) ENTOMBMENT ROSE HILL MAUSOLEUM JULY 4 1999 CUMBERLAND MARYLAND 22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME 23a. Part I. Entar tha diseasa, or complications that caused the deeth. Do not enter the mode of dying, stuch as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Immediate Cause (Final SEPSIS diseasa or condition rasulting in death) Dua to (or as a consequence of): GASTRO INTESTINAL BLEEDING Sequentially list conditions, if any, laeding to immadiata cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Lasf Dua to (or as a consequence of): PEPTIC ULCER DISEASE Due to (or as a consequence of) Pert If. Other significant conditions contributing to death but not resulting in the underlying causa given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CORONARY ARTERY DISEASE 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yas 25. Was case rafarred to medical axaminar? 26. Placa of Death (Check only one) Hospitel: 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, alc. (Specify) 4 Homicide

HOME MAKER

mes State Registrar

5

STUART M. 31. Data tiled (Month, Day, Year)
JUN 29 1999



30. Nama and address of parson who completed cause of daeth (Item 23a) (Type, Print)

P. M.D.

HOPKINS HOSPITAL BALTIMORE

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

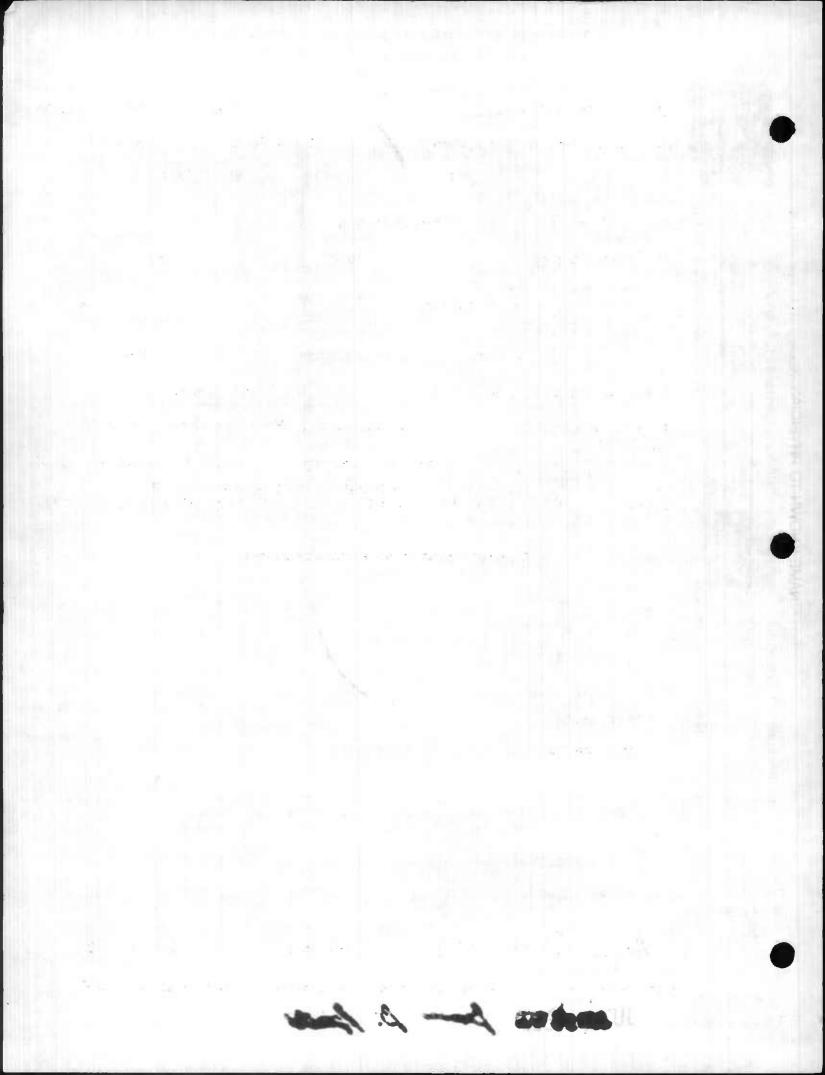
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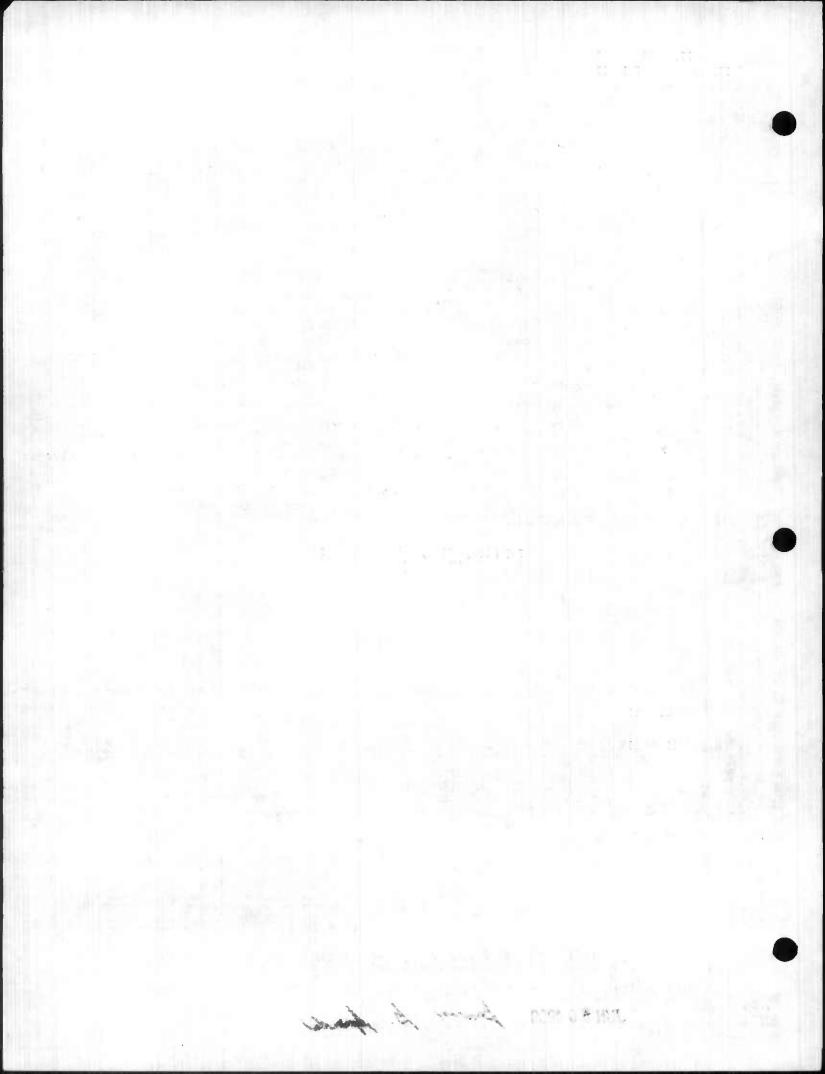
Physician /Medical Examiner	Willia										Month	Day	Year	
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			nd Healt	h Care	Syste	em			Perry		int	Ce	cil	
Funeral Director		2-664	6	X M 2□ F	7. Age (In y	rs. lest birthda Yrs.	Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Do.) 09/17/	ey, Year)	9. Birtl	hplaca (Stete or Fo buntry) D
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DHMH 16 Rev 6/95

State Registrar



DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** WILLIAM R. BROWN June 23, 1999 12:30 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 118 Seymour Street Cumberland Allegany If Under 24 Hrs. If Under 1 Year Months Days 8. Data of Birth (Month, Day Year) 1903 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F 95 214-16-2039 Yrs. Director **Usual Residence of Decedent** the Meryland 10b. County 10c. City, Town or Location 10d. Inaida City Limits r than "natural", or itama 23a or 28a-f show the Medical Examinar must be notified at Director 1 Yes 2 No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WITH 118 Seymour Street 21502 USA deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces2, 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dataa: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 14. Race - American Indian, Black, Whita, atc. filed within 72 hours efter Hygiene. Wher than "natural", or its 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: white Àq 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Heelth and Martel Hyglent Important: if tem 27 ie marked other tha any finjury or other treumatic event, that page. Retired Custodian Church 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Alfonzo Brown Laura (Rice) 19a. Informant's Name/Relationship (Type, Print)
William A. Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
118 Seymour Street; Cumberland MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Memorial Park 6/26/ Cumberland, MD 21. Signature of Funeral Service License 25carper 1 Funeral Home P.A. Cumberland, Maryland 23a. Part1. Enter the disease, or comblications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Batween Onsat and Death **Physician** /Medical Immediata Cause (Finel disease or condition resulting in death) atterrobrow Examiner Due to (or as a consequence of): Examiner physicien end s the burlei-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? Records, P.O. 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown advoned age by 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed deception ulca P490 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: efter deeth. director. 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Homa 5 🕅 Residence 6 ☐ Othar (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? edical Certification: Affer 5 Pending investigation 1 Natural To the Hospital or Attendit within 24 hours effer death. To the Funeral Director: Al completely filled in by the fu 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3 D17565 June 23, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mis Anthony Bollino, Jr., M.D.; 922 National Highway; LaVale, MD 21502 31. Data filed (Month, Day, Year) 32. Registrar's Signetur State

DHMH 16 Rev 6/95

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June B. Jones

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Bradford Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Day Year **Physician** CHARMAINE CULVER BRADFORD 29 1999 08:12 PM. June /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Salisbury Peninsula Regional Hospital Wicomico If Under 1 Year If Under 24 Hrs. Date of Birth (Month Day Year) 25/60 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Missouri 38 221-46-6136 Director Usual Residence of Decedent 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahou. Md. Worcester Newark 1 Yes 2 No Directo 'natural', or hams 23a or 25a-f olicel Examiner must be notifis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8506 Newark Road 21841 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: hours after 1 Never Married 2 Married altimore. Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specity: p 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Convenience Store Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) business owner/operator 12 4 and farm permit. Pages 1 and 2 should be Ills.
Department of Health and Mental Hy.
Importants If New 27 is merited other any Injury or other treather other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 88 James Cecil Janice Hill Cecil 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Bradford (Husband) 8506 Newark Rd., Newark, Md. 21841 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Memories 7/2/99 Newark, Md. 21. Signature of Funerel Service Licensee 22 Name and Address of Facility P.O. Box Dennis Funeral Home, Snow Hill, Md. 21863 3- Dennis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner onsequence of Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of) 080 P.O. ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown signed b by should 24b. Were autopsy findings available prior to Completed 24e. Was an autopsy performed? completion of cause of death? 1 Ves 2 No 1 Yes 2□ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this sertifica completely filled in by the funeral director. Be 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) 1√ Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Day Year)

28b. Time of Injury

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28c. Injury

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28d. Place of Injury. At home, farm, street, factory, office building, etc. (Specify)

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific O.C.M.E. June 30, 1999 30. Nam address of person who completed use of death (Item 23a) (Type, Print)

12 State Registrar

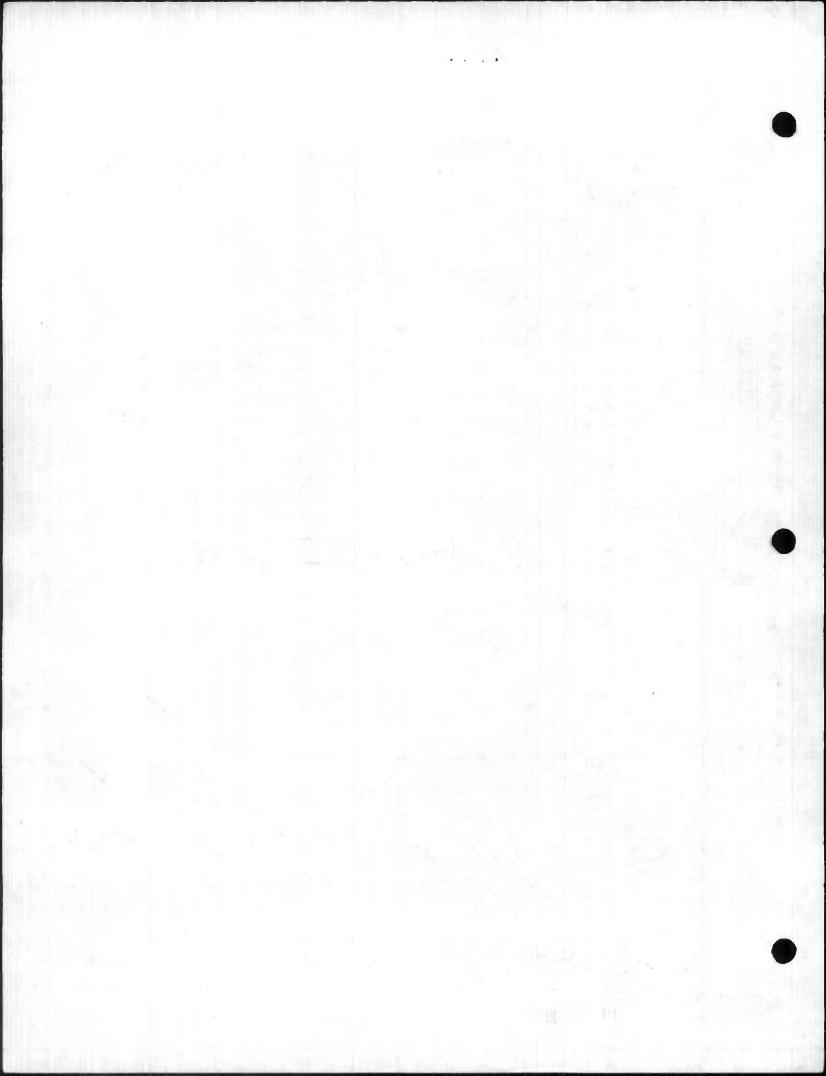
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restamen 111 Penn Street, Baltimore, Maryland 21201 32. Flagishrar's Signatura

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Daath Dey Month 1999 0530 JUNE Markus Osborne 23 Corn 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Fallston Harford Fallston General Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Data of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Min. Days Hours 100 M 2□ F Months 237-34-8171 92 June 19, 1907 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 200No Maryland Harford **Fallston** 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 1900 Harford Road 21047 USA 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 1 Nevar Married 2 Married Specify: White 1 Yes 2₺ No Specify: 3 ☐ Widowed 4 ☐ Divorced Yaar or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Sheet Metal Worker U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Ella Hamilton Roberts Patrick Henry Corn 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Brenda C. Eckstein / Daughter 2915 Pemwood Ct., Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata Burial 2 Cramation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Christian Church Cem. 6-26-99 Joppa, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 23a. Parl 1. Enter tha disaase, or comshock, or heart feilure. List only 50 W. Broadway Street, Bel Air, Maryland 21014 plication that caused the death. Do not enter that mode of dying, such as cardiac or respiratory errest, one cause on each line. Immediate Cause (Final CONGESTIVE HEART FAILIURE disease or condition resulting in death) Due to (or as a consequence of): STENOSIS ORTIC Sequantially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings availebla prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 1 Yes 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

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Baltimore, Maryland 21215-0020

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Examiner Physician/Medical the 98 esn 0 þ 2 Completed Be 2

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29a. Certifier

(Check only one)

physician certificate be ed by the e Division of Vital Records, P.O. has After this certificate funeral director, after death. filled in by ö 24 hours a completaly

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25. Wes case referred to medical axaminar? 1 Yes 2 No

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident

3 Suicide 4 Homicide

6 Could not be determined

2 ER/Outpetient 3 DOA 1 Inpatiant 28a. Date of Injury (Month, Dey Year)

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

2 Medical Examinar: On the bests of examination and/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and mannar stated.

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) to cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

29b. Signature and titla of certifiar

29c. License number D 45921 29d. Data signed (Month, Day, Year)

- MD -30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 5 YE) F. MAH MOOD AVENUE AIR MARYLAND 21014

State Registrar

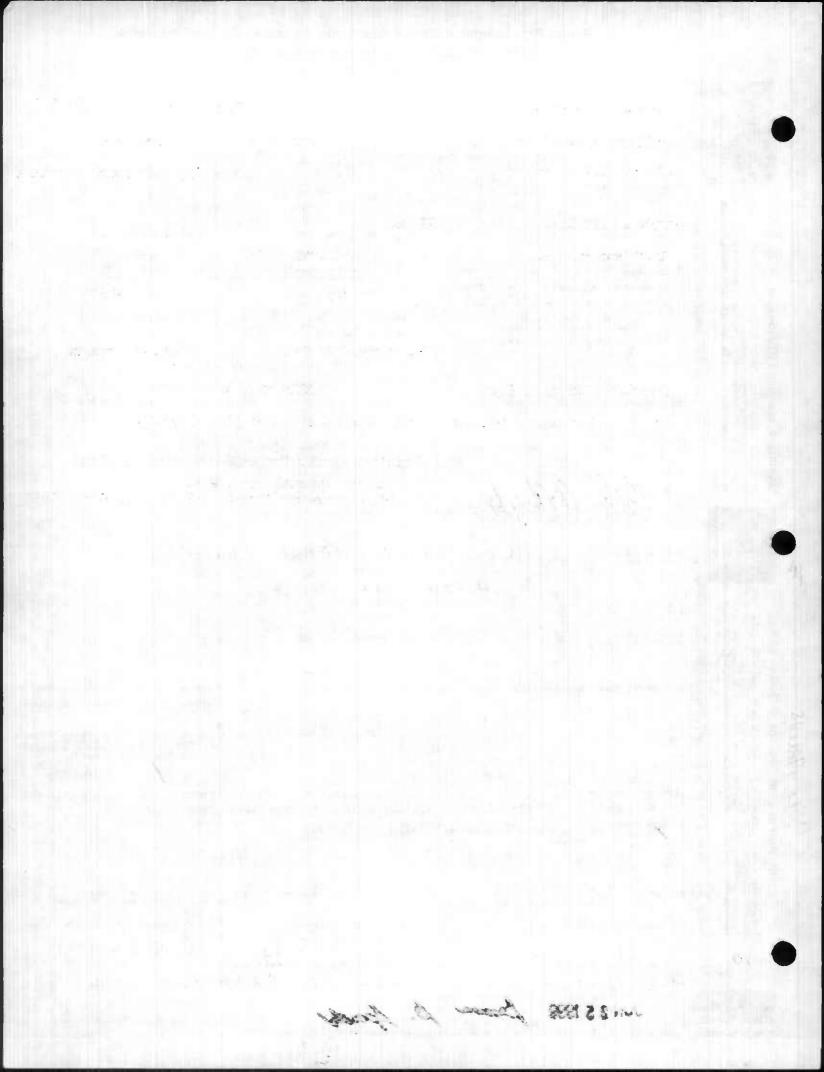
NORTH 31. Date filed (Month, Dey, Year) JUN 2 5 1999



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State of Maryland / Department of Health and Mental Hygiene

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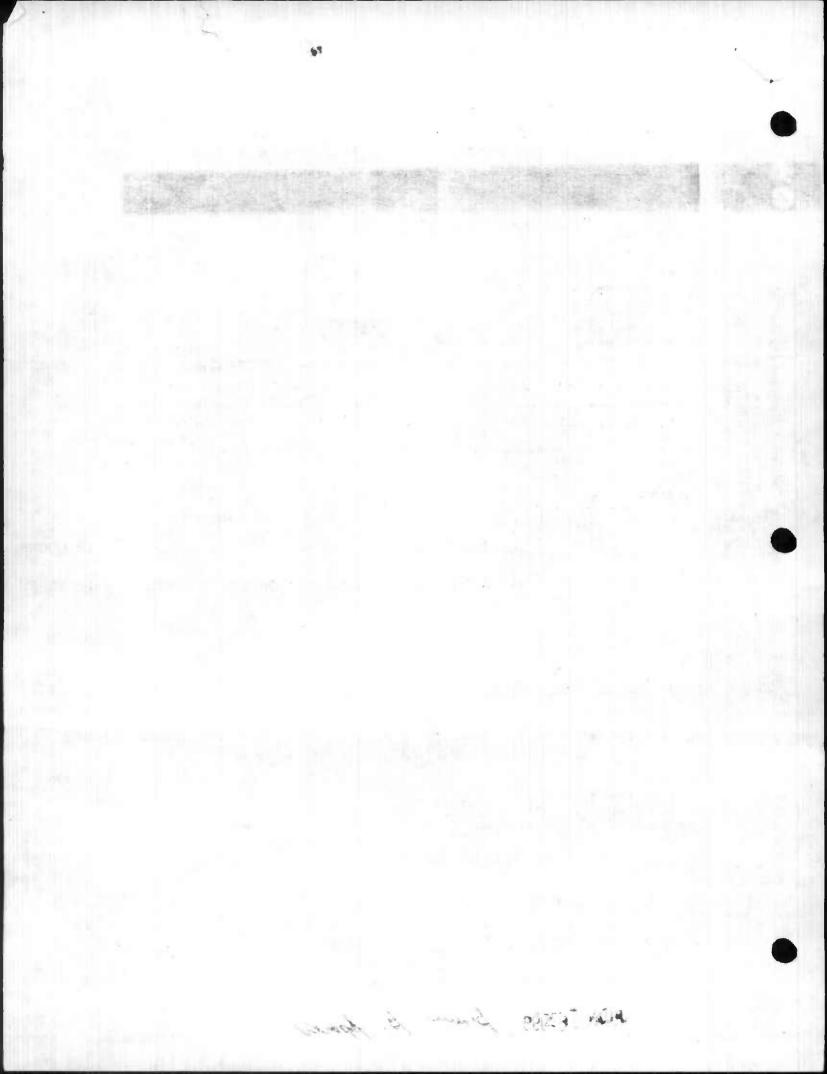
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Examiner	4a Facility Neme (If not institution, g Saint Joseph		Location of Death						
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pun a	Usuel Residence of Decedent 10a. State 10b. County	10c. C			10d. Inside City Limits				
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or 28s-f s be notified Director	10e. Street and Number			10g. Citizen of V	hat Country?				
23a mart b	516 Monkton I	Road		211			U.S		
	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Apped Forces? 1 ဩ Yes 2 □ No II Yes, Give Year or Dates: WW	If Yes, specify Cuban, Mexican, Puerto			pecify Yes or No to Rican, etc.)	Blsc	- American Indian, k, White, etc. : White	
d 2 should be filed within 72 hours at the and Markel Hygiere. It and Markel other than "natural", or treamwife event, the Medical Example To Be Completed by F	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)	(Give I		during most of wo d)	rking	16b. Kind of Bu		
	1.2 17. Fsther's Name (First, Middle, Las	t)	Snop	Superv		ne (First, Middle,	Tool		
Mental Harbard of street o	George Arthur					Pearl		9	
1995	19a. Informant's Name/Reletionship	(Type, Print)	19b. Mailin	g Address (Street	and Number or Ri	ural Route Numbe	er, City or Town,	State, Zip Code)	
and 2 saith a n 27 is ser tra	Ronald M. Cro				on Rd.,	Monkto	on, MD	21111	
Pages 1 ment of H tant: if ited jury or oth	20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donetion 5 Other (Spec	□Removal from State H∈	osters)	United N Cemet		1999	Herefo	City or Town, State	
Depart Depart Import any in ans in	21-Signature of Funerel Service Lice	Land	2	4 Secon		New Fre	edom, 1	nc. PA 17349	
	23a. Psrt1. Poter the disease, or con shock, or heart failure. List onl	no cations that caused the de-	ath. Do not ente	r the mode of dyi	ng, such es cardia	c or respiretory a	rrest,	Approximete Interval Between Onset and Death	
Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	CARDIAC F						12 HOURS	
D = L		ARTERIOSC	(or as a consequEROTI		NARY AR	TERY DI	SEASE	10 YEARS	
cate be executed physician and s the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):							
	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):					
death d for i	Part II. Other significant conditions	contributing to death but not re	sulting in the un	derlying cause ni	ven in Pert I	23b. Did i	lohacco usa cor	ntribute to the cause of death?	
ed by the detache							1 X Yea 2 No 3 Probably 4 U		
aw requir 1s been s 2 should							an sutopsy med?	24b. Were autopsy findings avsilable prior to completion of cause of death?	
The law requires the state has been signed page 2 should be completed by						101	Yes 213 No	1 ☐ Yes 25 No	
delan: The Lector, page	25. Wss case reterred to medical examiner?	Manitel		l ou		ath (Check only o	one)		
hys his a To	1 Yes 2 No 27. Manner of Desth 1 Natural 5 Pending 2 Assident Investigati	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	ry st rk?	lome 5 ☐ Resid 28d. Describe I	dence 8 Other		
al or Attending P rs after death. al Director: After ed in by the funer: Certification:	2 Accident Investigative 3 Suicide 6 Could not determined	28e. Plece of Injury - At	M 1 ☐ Yes 2 ☐ No 28e. Plece of Injury - At home, farm, street, factory, office building, efc. (Specify)				Street and Numb vn, State)	er or Rural Route Number,	
Hospit 14 hour Funer tely fill		hysician: To the best of my kn miner: On the basis of examin and manner stated.							
To the comple	29b. Signeture and title of certifier	29d. Date signer	(Month, Day, Year)						
	D38655						6/30/99		
11/1/2		NEY M.D., 7	601 09		IVE, TO	WSON, M	IARYLAN	D 21204	
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Sign		1					

DHMH 16 Rav 6/95



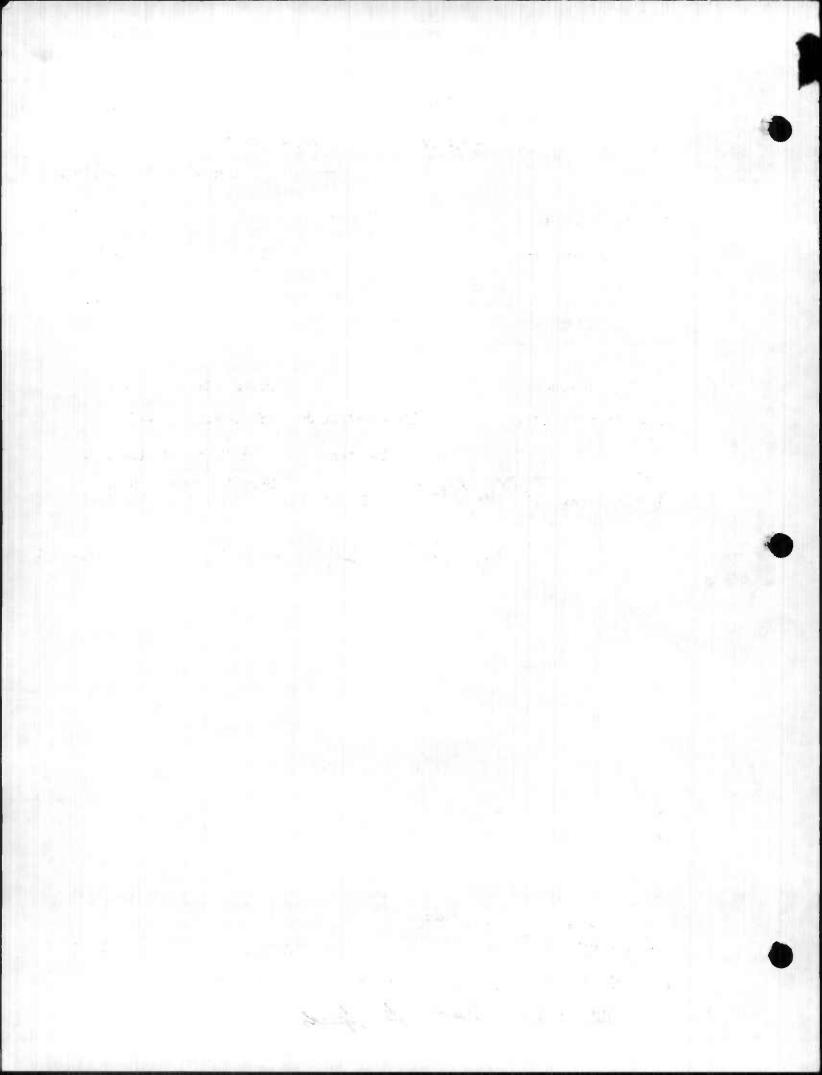
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amended Item #7, Per F.D. State of Maryland / Department of Health and Mental Hygiene () 6/24/99, Carroll County, wil Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Month **Physician** 1999 20149 harms -av- au June /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** H Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) THE JOHNS HOPKINS
5. Social Security Number 6. Sex 405 7. Age (In yrs. lest birthday) Birthpleca (State or Foreign Country) **Funeral** 1 M 2 X F Yrs. Director June 6, Maryland Unknown Usuai Residence of Decedent with the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f sho treumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Maryland Director Carrol1 Taneytown 10e. Sireet and Number 10f. Zip Code 10g. Citizen of Whet Country? 138 Carnival Dr. 21787 U.S.A. Funeral deeth 14. Raca - American Indien, 11. Maritel Status 12. Wes Decedeni Ever in U,S. Armed Forces? Was Decedeni of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelth and Mental Hygiana. Important: If item 27 is marked other than any injury or other transmitted other than the permitted of the perm Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: by **Black** 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elemeniary/Secondery (0-12) Coilege (1-4or 5+) None None 0 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Desiree Lavell Charms Matt Thompson 19a. Informani's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Taneytown, MD 21787 Desiree Charms/ mother 138 Carnival Dr. 20b. Piace of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Remove from State 6/25/99 Uniontown, MD Mt. Joy Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
Hartzler Funeral Home 21. Signaldia of Fuperal Service Licens Union Bridge, MD 21791 6 E. Broadway Part. Enter the disease, or complications thei caused the death. Do not enter the mode of dying, such es cardlec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition Examiner Examiner requires that the death certificate be executed physician and the burial-tran Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medicai the Due to (or as a consequence of): Part If. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? signed by the 1 Yes 25 No 3 Probably 4 Unknown P 24b. Were autopsy findings evailable prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? has page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician:
 24 hours after deeth.
 Funeral Director: After this certific. funeral director, 25. Was cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 1 Inpatient 28e. Date of injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of 1 Naturei 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurat Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Phyerclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture and little of carrille MD June 22 30. Name end address of person who completed cause of death (item 23a) (Type, Print) Mark J. Redmond, M.D. Baltimore m 1 21205 Wolfe Street

State Registrar 31. Date filed (Month, Dey, Year)

JUN 2 4 1999

r's Signature &. Spark



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of the CORBIN ALPINE D. 3, 1999 4c. County of Death 23 08 40 June 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER if Under 24 Hrs. 8. If Under 1 Year Dete of Birth (Month, Day, AN. 8, 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign Deys 1□ M 2□ F 58 SALTSBURY, MD. 10c. City, Town or Location 10d. Inside City Limits 1√ Yes 2 No SALISBURY WICOMICO 10g. Citizen of Whet Country? 10f. Zip Code USA 409 ROSE STREET 21801 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Û No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. Specify: BLACK 1 Yes 2 No 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) HOUSEKEEPER College (1-4or 5+) DOMESTIC 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) FULTON SLEMMONS, SR. EDITH MAPP

19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

6-28

22. Name and Address of Facility JOLLEY MEMORIAL CHAPEL

1213 JERSEY ROAD, SALISBURY, MD. 21801

20b. Place of Disposition (Neme of cametery, cremetory or other place)

NYRTLE BEACH, S.C. 29577

Dete 20c. Location - City or Town,

Do not enter the mode of dying, such as cardiec or respiretory errest,

28a-f ahow item 27 is marked other than "natural", or items 23a or 28a-f abov other traumatic event, the Medical Examinar must be nothing at the deeth 72 hours efter Hygiene. Department of Health and Mentel Hygis Important: If them 27 is marked other any injury or other traumatic event, it Peges 1 and 2 should be Baltimore, any Ir

Physician

/Medical

Examiner

2

Director

Funeral

þ

10a. State

MD.

11. Maritel Stetus

10e. Street and Number

Funeral

Director

5. Sociel Security Number

219-36-7305

Usuei Residence of Deceden

1 □ Never Merried 2 □ Married

3 Widowed 4 Divorced

Elementery/Secondary (0-12) 11th +1= 12

20a. Method of Disposition

23a. Part1. Enter the

19e. informent's Neme/Reletionship (Type, Print)

4 ☐ Donetion 5 ☐ Other (Specify)

FREDERICA CORBIN DYER/DAUGHTER

1 X Buriel 2 Cremation 3 Removal from State

10b. County

Physician /Medical Examiner

> ettending physician and for use es the bunal-transit 98 the signed by the peen hes certificate

þ

Completed

Be

10

Certification:

edicai

certificate be executed Box 68760, that requires The law Division of Vital Physician: eral Director: After this filled in by the funeral di or Attending death. efter

Physician/Medicai Examiner

Immediate Ceuse (Finel disease or condition resulting in deeth) Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or es e consequence of):

Due to (or as a consequence of) co Due to (or es e consequence of)

GREEN ACRES MEM. PARK

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

1 Yaa 2 No 3 Probably 4 Unknown 24e. Wes an autopsy performed?

20c. Location - City or Town, Stete

23b. Did tobacco usa contributs to the cause of death?

WEST RD. SALIS. MD.

24b. Were autopsy findings eveileble prior to completion of cause of deeth?

Approximete Interval Between Onset and Deeth

2 No

28d. Describe how injury occurred

1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Menner of Death

1 Naturel

3 ☐ Suicide

2 Accident

4 Homicide

28a. Dete of Injury (Month, Dey Year) 5 Pending investigation

1 Inpatient

Hospitel:

28e. Pieca of injury - At home, ferm, street, factory, office building, etc. (Specify)

2 ER/Outpetient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28c. injury at Work?

1 Tyes 2 No

281. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)

12 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end placa, end due to the ceuse(s) and menner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and pleca, and due to the cause(s) and menner stated. 29c. License number 29d. Dete signed (Month, Dey, Year)

26. Place of Death (Check only one)

29b. Signeture end title of certifier 20

6 Could not be

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print)

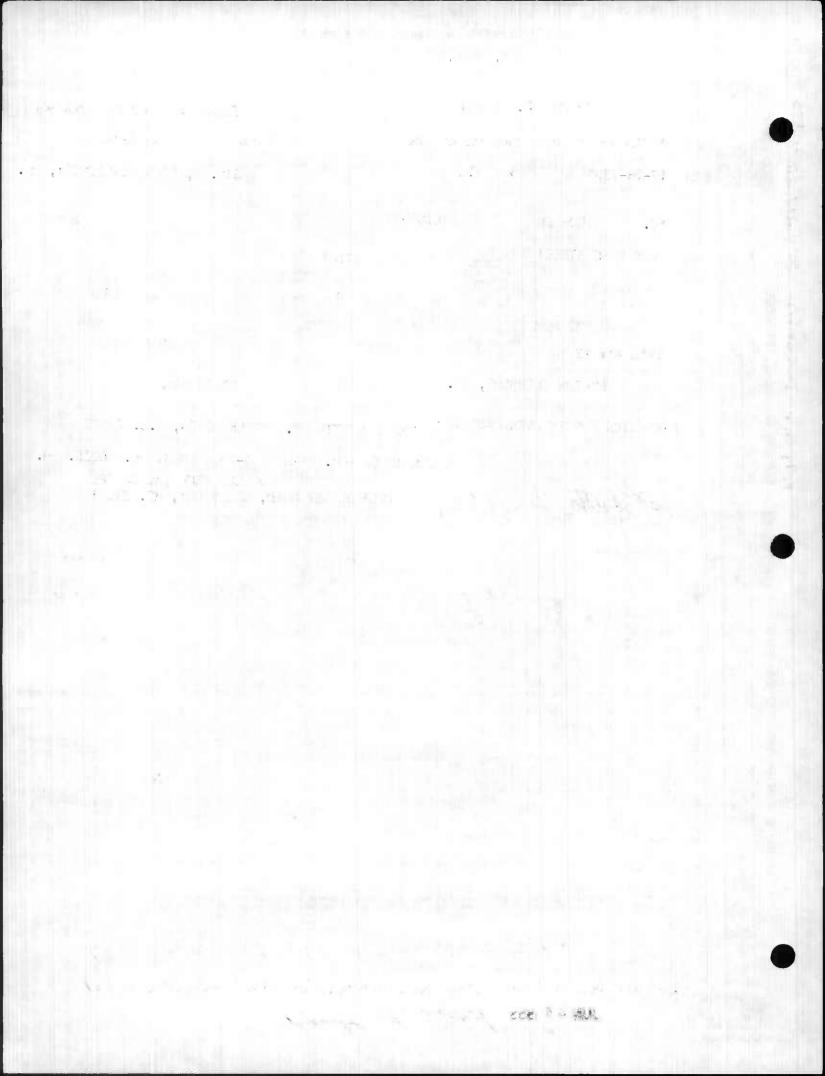
Robins Jalisbury Md William Healthway Drive 1104

State Registrar 31. Date filed (Month, Dey, Year) 2 8



24 hours

within 2 the th



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month LOUISE 26, 1999 ALICE CALDWELL 0005 JUNE 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) BERLIN If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) ATLANTIC GENERAL HOSPITAL WORCESTER 5. Sociel Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 KF Months Days Yrs. 219-34-7016 Usual Residence of Deceden 85 7-30-13 PA 10b. County 10a Stete 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No MD. WORCESTER OCEAN CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10450 RD. 21842 NEW QUAY USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent'e Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) CHARLES WINTERMYER EDNA BUFLAP 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LOUIS F. CALDWELL 20a. Method of Disposition SPOUSE 10450 NEW QUAY RD., OCEAN CITY, Mp, 21842 20b. Place of Disposition (Name of cametery, cremetory or other place) 1 Burial 2 □ Cremation 3 □ Removel from State GARDENS OF THE PINES 6-29 OCEAN PINES, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Füheral Service Licens 22. Name and Address of Facility BERLIN, ULLRICH FUNERAL HOME MD. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death SEPSIS Immediete Ceuse (Finel disease or condition resulting in death) Due to (or es e consequence ot): CLOSTRIDIUM OIRALE INFECTION (COLITS Due to (or as a consequenca of): Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown

Physician /Medicai Examiner

Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nature!", or items 23s or 28s-f show any injury or other traumatic event, or a Medical Examinat must be notified at once.

5/26/99 000

Alice Caldwell

or Attending Physician:

After

24 hours after decidence to Funeral Director plately filled in by the

To the Hosp within 24 hor To the Fune completely fi

after death. Director: Af

physician and the burial-transit signed by the a ate has pege 2 s certificate this

Physician/Medicai þ Completed Be Certification: To

Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last

1 Yes

27. Manner of Deeth

1 Natural

2 Accident

3 Suicide

4 Homicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy

1 ☐ Yes 2 ☐ No 1 Yes 2 LINE

25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA . Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending 2 No Investigation 6 Could not be determined

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) and manner as steted.

29a. Certifier 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier

d cause of death (Ife) 23a) (Type, Print) 30. Name and address Healthway Drive

Jan, ald 2/8/1

State Registrar

Medical

31. Date tiled (Month, Dey, Year)

32. Registrer's Signature

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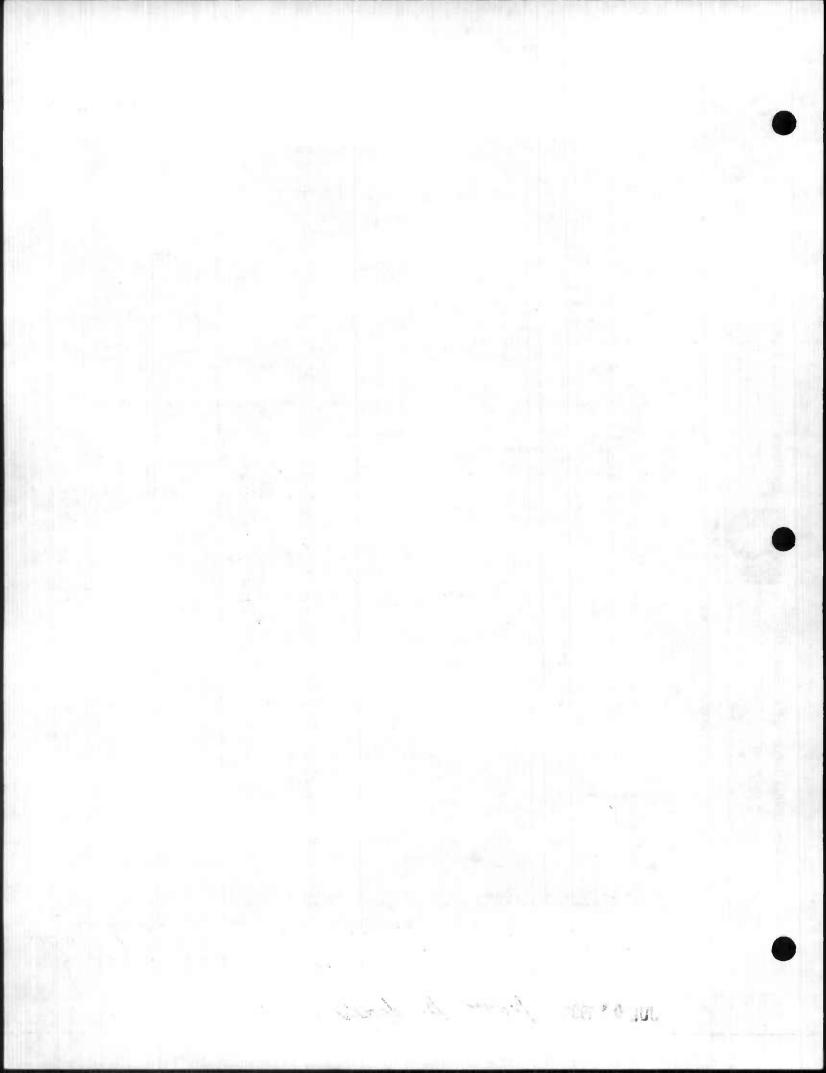
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** James Dawson 28 06 1999 15:59 /Medical 4e Fecility Neme (Il not Institution, give street and number) 4b. City, Towh, or Location of Death 4c. County of Death Examiner Sacred Heart Hospital Cumberland Allegany I If Under 24 Hrs. 8. Dete of Birth Nov 9, 1963 5. Social Security Number If Under 1 Year Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Deys Months 1 M 2 F Hours 216-96-6944 MD 35 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show with the Maryla 1 ☐ Yes No Director Mineral Ridgeley 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? b 26753 RD 1 Box 412 USA Norms 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 You If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Merital Status o filed within 72 hours after of I Hygiene. other than "natural", or item Bleck, White, etc. 1 Never Married 2 Merried Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: white á 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Rural Carrier U.S. Postal Svc permit. Pages 1 and 2 abouid be filed w Department of Health and Mental Hygien Important: If then 27 is marked other th any Injury or other traumafic accord. 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) 8 (Merkel) Edward D. Dawson Carol L 19e. Informent's Neme/Reletionship (Type, Print)
Carol L. Dawson 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) RD 1 Box 412; Ridgeley, WV 26753 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 Laurief 2 Cremetion 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Restlawn Memorial Gard7/01/ LaVale, MD 21. Signeture of Funeral/Service Licensee 235 Tree P.A. Cumberland, Maryland 23a. Pert1. Enter the disease, or complications that baused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List prin one cause on each line. Approximete Intervel Between Onset and Death **Physician** framediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner physician and s the burial-transit The law requires that the deeth certificets be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760, Physician/Medical Due to (or as e consequence of): 980 jo 23h. Did tohacco use contribute to the cause of deeth? Division of Vital Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. the P 1 Yes 2 No 3 Probably 4 Onknown þ 24b. Were eutopsy findings evaileble prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? Deed has page 2 a 1 Yes 2 No 1 ☐ Yes 2 No certificate 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No this After this 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred i or Attending P after death. Director: After t d in by the funeri Certification: 1 Netural 5 Pending investigation 2 Accident 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide To the Hospital or A within 24 hours after To the Funeral Directompletely filled in b. edical 29a. Certifie Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end menner as stated 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 2 29c. License number 29b. Signature end title of certifier 29d. Date signed (Month, Dev. Year, 15 D28910 30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print)

H.C. Merrick M.D. 500 Memorial Avenue Cumberland MD H.C. 21502 ny 32. Registrar's Signeture 31. Date filed (Month, Day, Year) State 0 2 1999 Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Dey **Physician** DONALD NORRIS DARBY 25, 1999 4c. County of Death 0045 June /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY Months Days Hours Min. 07/13/26 Sex 1D M 2□ F 5. Sociei Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Donald Darby SS# 218-16-8911 **Funeral** Months 218-16-8911 Virginia Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahow edical Examiner must be notified at 1 ☐ Yes 2 No Director VA Accomack Atlantic 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32277 Powers Lane, P.O. Box 591 23303 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 by Yes 2 □ No IVes, Give 1 4 1 - 4 4 Funer Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1□ Yes 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than "nature traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2 should be filed within and Mental Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) 11 Cargo Handler Airlines 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adrian Darby Marie Bailey 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 591, Jessica Darby (Wife) Atlantic, VA 23303 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 0 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) = 8 Downing Cemetary 6/28/99 Oak Hall, VA 22. Name and Address of Facility Holloway Melson Funeral Home, P.A. 21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heert feiture. List only one cause on each line. 103 Linden Ave., Pocomoke City, MD **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Physician/Medical Examiner law requires that the death certificate be axecuted physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 80 signed by the a d be datached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? 1 Yes 2 No 3 Probably Unknown py 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Was an eutopsy Completed is certificeta has director, page 2 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) To Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2500 1 Apatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) funeral 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: Aftar 1 Naturai s after de.

I Director: An.
by the fu 5 Pending 1 Yes 2 No Investigation 2 Accident n 24 hours after dea ne Funeral Director nietaly filled in by th 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 6 1 Eartifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) Medical To the Hosp within 24 hor To the Fune completaly fi 29d. Dete signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (item 23a) (Type, Print) CONSTANTA 10+ 31. Dete filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

JUN 2 8 1999

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signed by the atte Deed certificate has funeral director, this

Certification: death. filled in by

P.O. Division of Vital Records,

Funeral

Scarpelli

(215-36-7892)

Fletcher

To the Hospital or Attand within 24 hours after death To the Funeral Director:

Medical 5 hus

Registrar

Physician/Medical Completed by Be 10

> Sunil K. 31. Data filed (Month, Day, Year)
>
> JUL 0 2 1999

25. Was case rafarred to medical

5 Panding

invastigation

6 Could not be detarmined

1 ☐ Yas 2 ZKNo

axaminar?

27. Manner of Death

1 Netural

2 Accidant

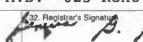
3 Suicide

29a. Cartifian

4 Homicida

(Check only one)

29b. Signatura and title did



Part ff. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part f.

1 Inpatiant

28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA

28b. Time of

28a. Pleca of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28c. Injury at Work?

1 🗷 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. Licensa number

033280

1 ☐ Yes 2 ☐ No

DHMH 16 Rev 6/95

1999 30. Name and address of particle who completed causa of deeth (Item 23a) (Type, Print)
Sunil K. Gupta M.D. 625 Kent Avenue Cumberland MD 21502

Location (Street and Number or Rural Routa Number, City or Town, Stata)

29d. Data signed (Month, Day, Year)

23b. Did tobacco use contribute to the cause of death?

3 Probably 4 Unknown

24b. Wara autopsy findings available prior to

complation of causa of death?

1 ☐ Yas 2 ☐ No

1 Yes 2000

280 No

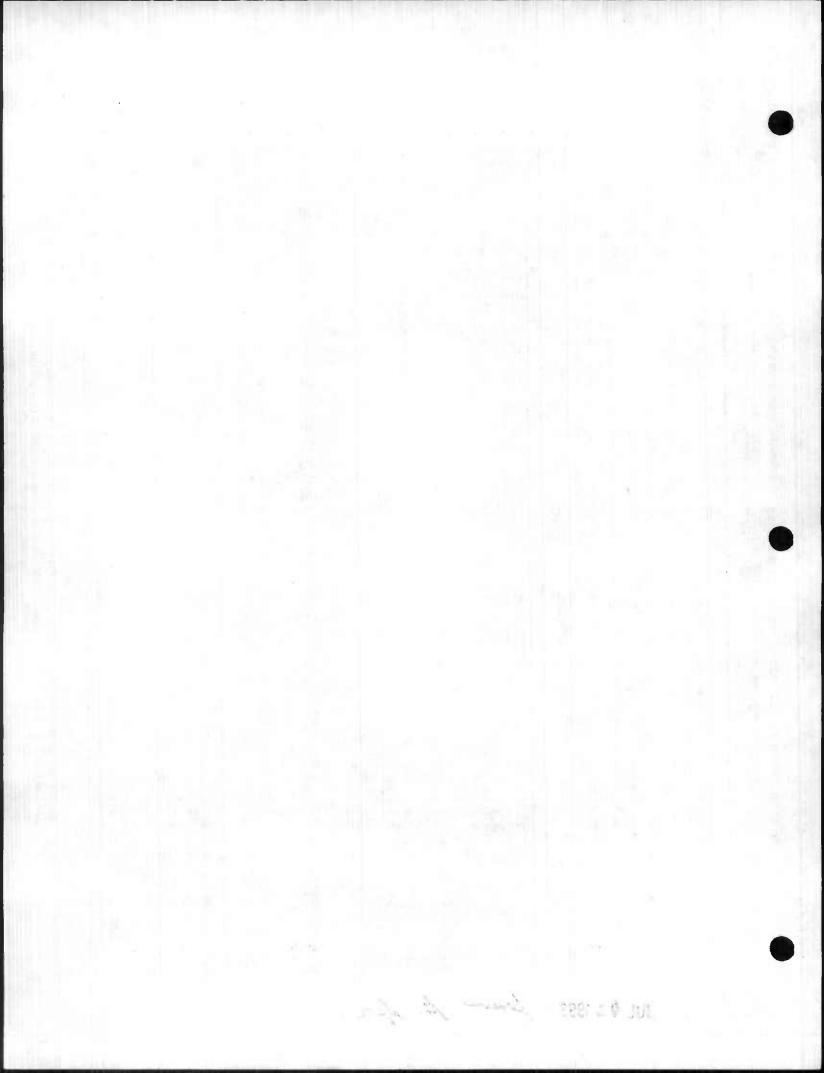
24a. Was an autopsy performed?

1 Yas

28d. Describe how Injury occurred

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

26. Place of Deeth (Check only one)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #1 PER MD G772 7-22-99 WR. Certificate of Death Gera 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** Month Albert Charles Gero 09:00 1999 /Medical June 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Lions Manor Nursing Home Cumberland Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Aug 28 (1906) 7. Age (In yrs. last birthday) Birthplece (State or Foreign County) **Funeral** 1□M 2□ F Days 214-05-9284 92 Yrs Director Usual Residence of Decedent death with the Maryland 10a. State "natural", or items 23a or 28a-f show adical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. inside City Limits Director 1 Yes 2 No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1500 D Old Towne Manor Apts. 21502 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bieck, White, etc. Pages 1 and 2 should be filed within 72 hours after of the control of the set 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 → to Specify: by 3 ☐ Widowed 4 ☐ Divorced Specify: white h and Mental Hygiene.
7 Is marked other than "natur treumatic event, the Medical Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ret Boilermaker Helper Textile 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Arsane N. Gero Annie (Stotler) 19a. Informant's Name/Relationship (Type, Print)
Laura M. Gero 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1500D Old Towne Mano; Cumberland MD 21502 or other t 20a. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 1 Daurial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 6/28/ Cumberland, MD 22 Scarbelli Foruneral Home P.A. Cumberland, Maryland 23a. Part1. Enter the disease, or complications theticaused the death. Do not enter the mode of dylng, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediate Cause (Final Diraton **Examiner** Due to (or es alton Examiner more The law requires that the death certificate be axecuted burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last and Due to (or es a consequence of) Lac Physician/Medical the Due to (or as e consequenca of): USB 8S signed by the attar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24e. Wes an autopsy performed? has paga 2 this cartificete 1 Yes 2 No 1 Yes 200 No or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 20 No 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred Aftar 28c. Injury at Work? 5 Pending investigation 1 Naturai aftar death. 1 Yes 2 No 2 Accident tha To the Hospital or Atter within 24 hours after der To the Funeral Director completely filled in by th 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

P.O. Box 68760, Records, Division of Vital

mis

Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and title of oftifier

A. Ranjithan, M.D., Lions JUN 2 5 32. Degistrar's Signature 1999

an

Name and address of person who opmpieted cause of death (Item 23a) (Type, Print) Manor Nursing Home, Seton Drive Extended, Cumberland

9750

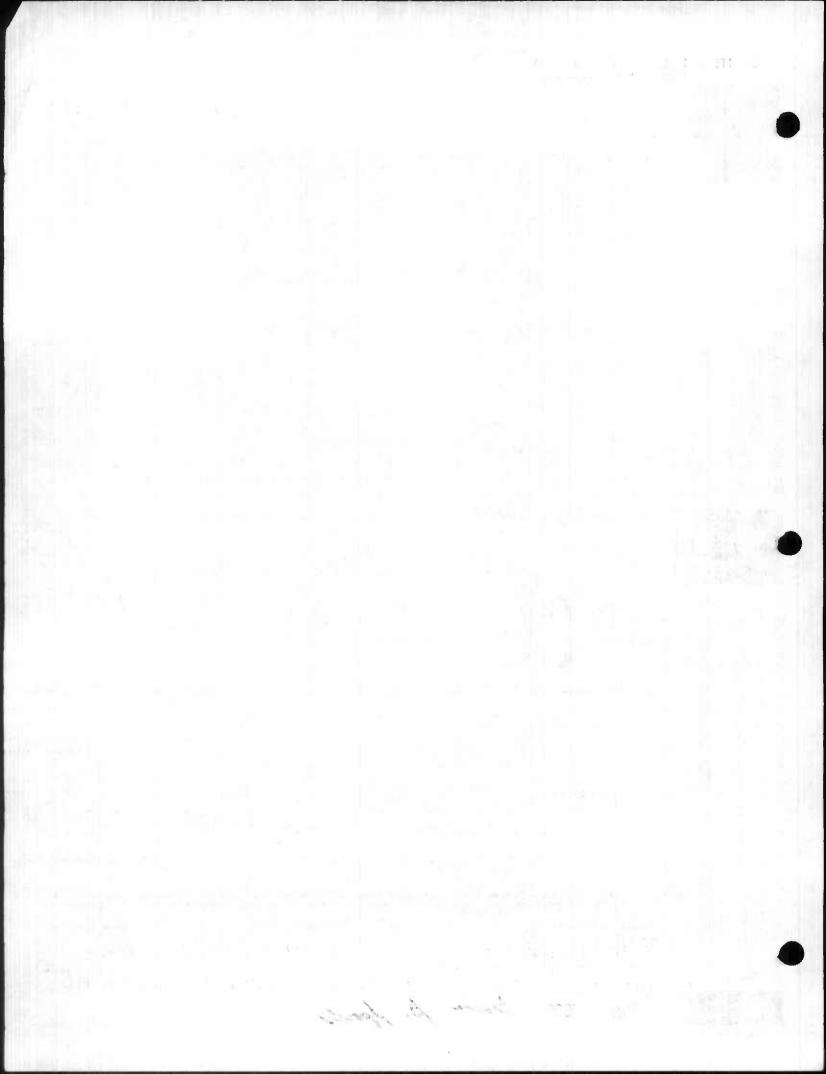
12 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number

29d. Dete signed (Month, Day, Year)

21502



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Jun 30, 1999 **Physician** 09:46am Milton Gerson /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Neme (If not institution, give street and number) Examiner Devlin Manor Nursing Home Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1914 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys 15 M 2□ F Months Hours Min. 217-28-9321 84 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Allegany Cumberland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be r 828 Camden Avenue 21502 USA Funeral 12. Was Decedent Ever In U.S. Agned Forces? 14 Yes 2 □ No If Yes, Give Year or Dates:WW II Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Merital Status Black, White, etc. 2 should be filled within 72 hours after 1 and Mental Physiene. Is marked other than "natured" or less 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0020 Specify: white by 3 ☐ Widowed 4 ☐ Divorcad 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Retired Attorney Law 18. Mother's Name (First, Middle, Malden Sumame) 17. Father's Name (First, Middle, Last) Morris Gerson Sarah (Shearer) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
828 Camden Avenue; Cumberland, MD 21502 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If them 27 is n Jeanne E. Gerson wife 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ò 4 ☐ Donation 5 ☐ Other (Specify) East View Cemetery 7/02/ Cumberland, MD 21. Signature of Funeral Service Licensee 25 carpel 1 f Tuneral Home P.A. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer feiture. List only one cause on each line. Cumberland, Maryland **Physician** Due to (or es e consequence of): /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and s the bunal-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in deeth) Lest Due to (or es a consequença of): that the death certificate be exec Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): SE 980 signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 TYes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: after death. Director: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ANaturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 ☐ Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ HomicIde 24 hours Hospital 1☐ Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1217505 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 45 GLIMITI Huy AJB. 11 inu MD mis 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Sports 0 2 1999 JUL Registrar

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by modely registrate

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

AMEND ITEM:	#23 PART I, per MD G773 7-1	7-99 WR. Ce	rtificate of E		Reg. No.	9 2 8 2					
Physician /Medical	cal A City Town or Location of Death As Country Death										
Examiner	COPPERRIDG			SYLESUTILE	CAR	ROLL					
Funeral Director	5. Social Security Number 214-24-2447 6. Sex 1 M 2	XF 7. Age (In yrs. last birthday) 106 Yrs.	If Under 1 Year Months Days	Hours Min. 8. Date of E (Month, Feb 6	dirth Year) 1893	Birthplace (State or Foreign Country) Ohio					
death with the Meryland rms 23a or 28a4 ehow r must be notified at neral Director	Usual Residence of Decedent 10a. State MD 10b. County Carroll	10c. City, Town or Lo	Sykesvil	le	-88	10d. Inside City Limits 11 Yes 2 □ No					
or 28e-f e notified	10e. Street and Number		10f. Zip Code	1704	10g. Citizen of W						
or Per Per	1 Never Married 2 Married	TVan aleman		1784 spanic Origin? (Specify Yes or N., Mexican, Puerto Rican, etc.) Specify:	U.S.A 14. Race Blace Specify:	- American Indian, k, White, etc.					
lene.	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) Co 1 2	(Give life.	dent's Usual Occupa kind of work done di DO NOT use retired) Dietician	uring most of working	16b. Kind of Business/Industry Nutritional						
A Heelth and Mental Hyg Item 27 Is marked other other treumatic event,	17. Father's Name (First, Middle, Last) Charles L. Ge	erlaugh	18. Mother's Name (First, Midd Julia Alne		θ)						
N = 2 5	19a. Informant's Name/Relationship (Type, Pri Ms. Lois Mills Lissa			nd Number or Rural Route Num Avenue, Baltim							
- O	20a. Method of Disposition 1 Burial 2 Kremation 3 Remove 4 Donation 5 Other (Specify)	20b. Place of Dispo	osition (Name of	Date	20c. Location -	City or Town, State					
pemit. Pege Depertment of Important: If eny injury or potes.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel, PA (Box 195) Sykesville, MD 21784 (410)-795-1400										
Physician /Medical Examiner	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau immediate Cause (Finat disease or condition resulting in death)	SENILE DEMENTIA	Dis	eccs e	arredt,	Approximate Interval Between Onset and Death					
physicien and sthe burdel-transit	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
the ettending the transfer hed for use e											
igned by the ettending be deteched for use by Physician/M	Part II. Other eignificant conditions contribution	to death but not resulting in the u	inderlying cause give		Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ◯ No 3 ☐ Probably 4 ☐ Unknown						
should should					as an autopsy formed?	24b. Were autopsy findings available prior to completion of cause of death?					
certificate has rector, pege 2				10	Yes 200 No	1 ☐ Yes 2/2 No					
director.	25. Was case referred to medical examiner?	t:	Othe	26. Place of Death (Check only							
00 0	1 162 5 7 140	1 ☐ Inpatient 2 ☐ ER/Outpatien Date of Injury (Month, Day Year) 28b. Time of Injury	1 28c. Injury Work	4) Nursing Home 5 He	sidence 8 LIOthe e how injury occurr						
To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 7	3 Suicide 6 Could not be determined 28e	Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office		(Street and Numb own, State)	er or Rural Route Number,					
he Hospit in 24 hour he Funer pletely fill adical	(Check only 2 Medical Examiner: Or	To the best of my knowledge, death the basis of examination and/or in d manner stated.	h occurred at the time evestigation, in my op	e, date and place, and due to the timion, death occurred at the time	e cause(s) and ma e, date and place, a	nner as stated. and due to the cause(s)					
To the transfer of the transfe	29b. Signature and title of certifier Meeting	Night, MD	29c. License	27111	6123	d (Month, Day, Year) 3 9 9					
	30, Name and address of person who complete ERNESTINE WRIG	d cause of death (Hem 23a) (Type, THT, COPPERRI	Print) DGE, 710	OBRECHT RO	DAD, SYLE	SVILLE, MD					
State	31. Date filed (Month, Day, Year) JUN 2. 4 199	32. Registra/s Signature	A 100	11							

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** WILLIAM GATEWOOD 99 1807 25 6 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner ATLANTIC GENERAL HOSPITAL BERLIN If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) WORCESTER 5. Social Security Number 6 Sax If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1.25M 2□ F Months Deys 414-14-3242 Director 80 TENESSEE Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health end Mentel Hygiene. 10c. City, Town or Location 10a State 10d. Inside City Limits 10b County Ves 2 No MD. Director WORCESTER OCEAN CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 134 PINE TREE RD. 21842 Funeral USA 14. Race - American Indian, "natural", or items : 12. Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 KNo Specify: by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WW WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than "nature traumatic event, the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DRIVER RETAIL BEVERAGE 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be ORA GATEWOOD ALTHEA RAWLS 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) THELMA C. GATEWOOD OCEAN CITY, MD., 21842 134 PINE TREE RD. SPOUSE 20b. Placa of Disposition (Name of cametery, crematory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 30 SUNSET M.P. 22. Name and Address of Fecility 21. Signature of Fugural Service Licenses ULLRICH FUNERAL HOME BERLIN, Mp. Point. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximata Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Physician/Medical Due to (or as a consequenca of) 23b. Did tobacco use contributs to the cause of death? been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ™Unknown 1 ☐ Yss 2 ☐ No à 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 ☐ Yes 2 ☐ No 1 Ves 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/OutpetienI 3 DOA Certification: To 28c. Injury et Work? 27. Manner of Death 28a. Date of Injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred or Attending Patter death. 5 Pending investigation 1 Natural 1 Tyes 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b 1 Cartifying Phyalcian: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) end manner as stated. 2 Madical Examiner: On the basis of examineticn end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Medical 29a. Certifier

State Registrar

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31. Date filed (Month, Day, Year) 8

29b. Signature and title of cartifier

9733 32. Registrar's Signature

51611-

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

29c. License number

Drie

29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

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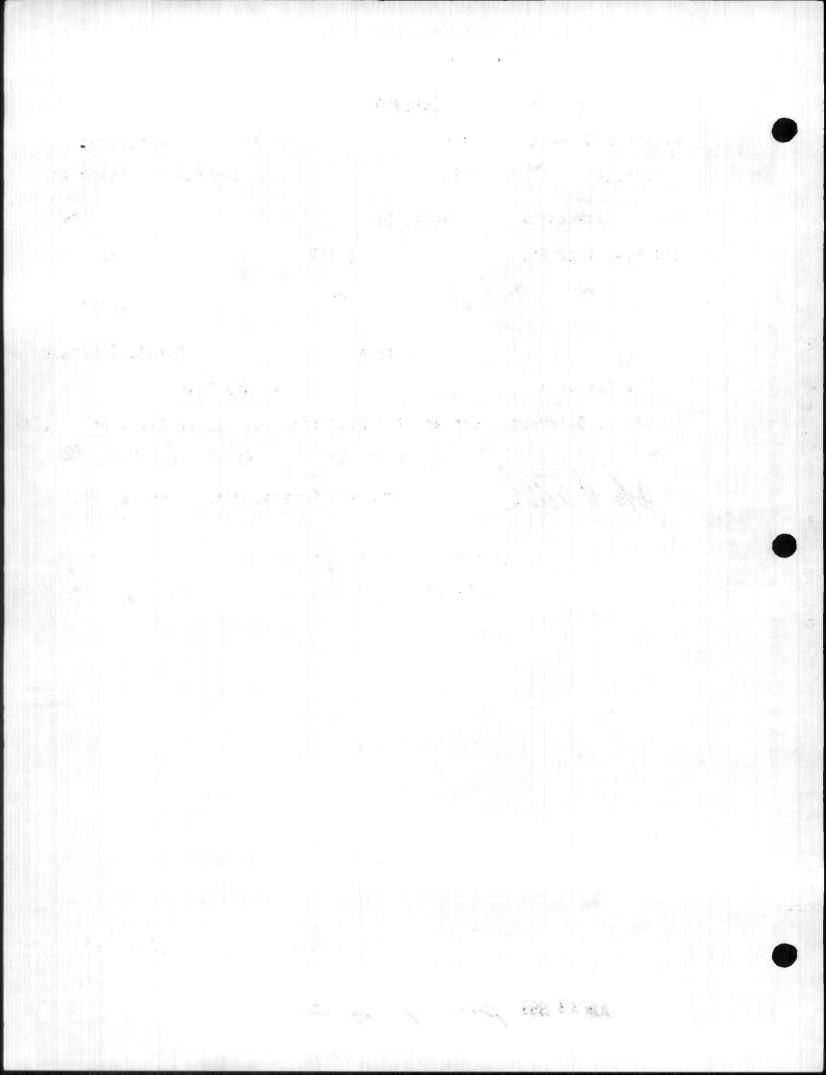
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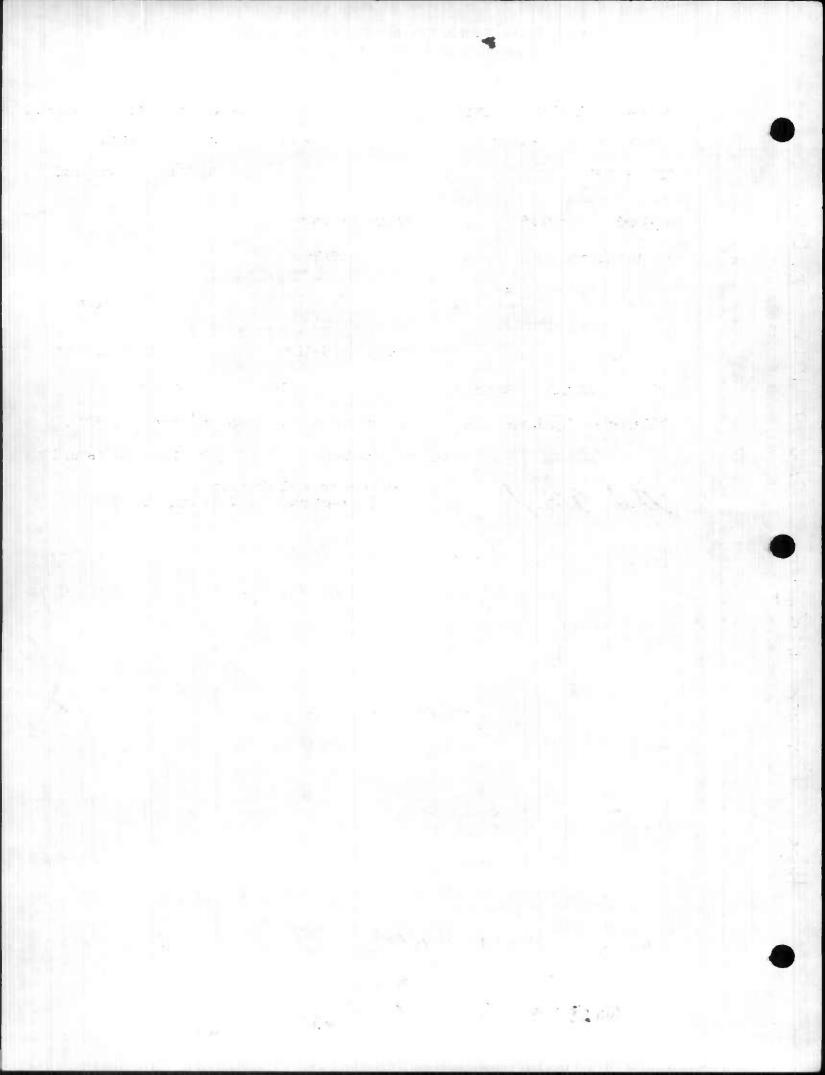
William Gatewood

Box 68760,



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death Dey Month Year **Physician** 10:15 A.M. RAYMOND RIGDON 26, 1999 4c. County of Deeth HOPKINS June /Medical 4b. Cify, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) Examiner Harford Memorial Hospital Harford 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** 1X0 M 2□ F Yrs. 82 Maryland Director 212-18-7138 Usual Residence of Deceden 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2010 Directo Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23s or other treumstic avent, the Medical Exemener must be 21078 USA 123 Darlington Road Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien. Black, White, etc. 1 Dyes 2 No If Yes, Give 1 ☐ Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Š 3 Widowed 4 Divorced Yeer or Dates: WW II White 16e. Decedent's Usuet Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed with Health and Mental Hygiena. Catalog Specialist U.S. Government 12 18. Mother's Neme (First, Middle, Melden Sumeme) 17. Father's Name (First, Middle, Last) Della Rigdon Noble -Hetrick Hopkins L. 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Health the Vallaree M. Hopkins - Wife 123 Darlington Rd., Havre de Grace, MD 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition important: if it any injury or o once. ⊠ Buriel 2 □ Cremetion 3 □ Removel from State 6/29/99 Havre de Grace, MD Rock Run Cemetery 4 □ Donetion 5 □ Other (Specify) 22. Name end Address of Fecility McComas Funeral Home, P.A. 21. Signeture of Funerei Service Licensee 236. Pert 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Dery Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final Ventricular plosi llation Due to (or as e consequence of): diseese or condition resulting in deeth) Examiner Examiner 120x1c physician and the burial-transit opkins, Agymond, & Ria Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury lhet initiated events resulting in deeth) Lest Physician/Medical Due to (or es e consequence of) 82 use a Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 🔊 ☐ Unknown Hypertension þ 24b. Were autopsy findings evailable prior to completion of cause Completed 24a. Wes en eutopsy performed? page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of Certification: Attending 1 Naturel 5 Pending 1 Yes 2 No 2 Accident investigation after deat Diractor: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Sulcide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 6 24 hours a Funerai D Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es stated. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated. 29e. Certifier Medical completaly (Check only one) within 2 To the i 29b. Signeture and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number BAIGMO MIRZA D4315 30. Name and eddiess of person who completed cause of deeth (Item 23e) (Type, Print) 1041

State Registrar -



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMEND ITEM: #1 PER MD G773 7-27-99 WR. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Otto Heberle 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Day ERNEST OTTO HERERLE 1:50 am 1999 24 /Medical June 4a. Facility Nama (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** LIONS MANOR NURSING HOME CUMBERLAND
If Undar 24 Hrs. 8. Da ALLEGANY If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Deys 1♥M 2□ F Hours 214-07-6117 81 Yrs Director OCT 14 1917 MARYLAND Usuel Residance of Dacedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits ns 23a or 28a-f show Director MARYLAND 1 Yas 2 No ALLEGANY LAVALE 10e. Street and Number 10f. Zip Coda 10g, Citizan of What Country? 1005 NATIONAL HIGHWAY 21502 U.S.A. Funeral Jash Hems 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, traumatic avent, the Medical Examiner Bleck, Whita, atc. filed within 72 hours aftar 1 Navar Married 2 Marriad ∏ Yas 2 □ No f Yes, Give rear or Datas: WW 1 1 Baltimore, Maryland 21215-0020 ŏ 1 ☐ Yas 2 ☑ No by 3 Midowed 4 ☐ Divorced Specify: WHITE 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Dapartment of Health and Mental Hygiene Important: If flam 27 is marked other than any Injury or other traumatic avant Elemantary/Secondery (0-12) College (1-4or 5+) B&O RAILROAD RAILROAD/BRAKEMAN 17. Fathar's Name (First, Middle, Last) 18. Mother's Nema (First, Middle, Meiden Sumame) Be HERMAN HEBERLE AMANDA SHULTZ 19e. Informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DALE MERRITT FUNERAL DIRECTOR 404 DECATUR STREET CUMBERLAND MARYLAND 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Other (Specify) CUMBERLAND CREMATORY JUNE 24 1999 CUMBERLAND MARYLAND 21. Signatura of Funeral Sarvice Licen 22. Nama and Addrass of Fecility MERRITT-ADAMS FUNERAL HOME P.A. art1. Enter the disease, or complications thet caused the death. Do not after the mode of dying, such as cardiac or respiratory arrest, interval Batwaen check, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Causa (Final disaase or condition rasulting in death) **Examiner** Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Cause (Disaasa or Injury thet initiated evants rasulting in daeth) Last and Due to (or as a consequance Box 68760. attanding physician Physician/Medicai Dua to (or as a consequance of): Part JL. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown by Completed 24b. Wara autopsy findings available prior to complation of ceuse of death? 24a. Wes an autopsy performed? cartificate has (en 1 Yas 2 No 1 ☐ Yes 2 1 No ann Be 25. Was cese refarred to medical axeminer? 28. Place of Deeth (Check only one) 1 Yas 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) 27. Mannar of Deeth 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Panding invastigation 1 Natural

Division of Vital Records, P.O. or Attanding Physician: Aftart daath. Director: tha the Hospital

Certification: within 24 hours after d To the Funeral Direct completaly filled in by Medical

> State Registrar

Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the ceusa(s) and mennar as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and mannar stated. 29b. Signetura and title of certifian

29c. License number

1 ☐ Yas

29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 Could not be datarmined

30. Nama and address of person who complat ed ceuse of daath (Item 23a) (Type, Print)

Lions Manor

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

Nursing Home, Seton Drive Extended

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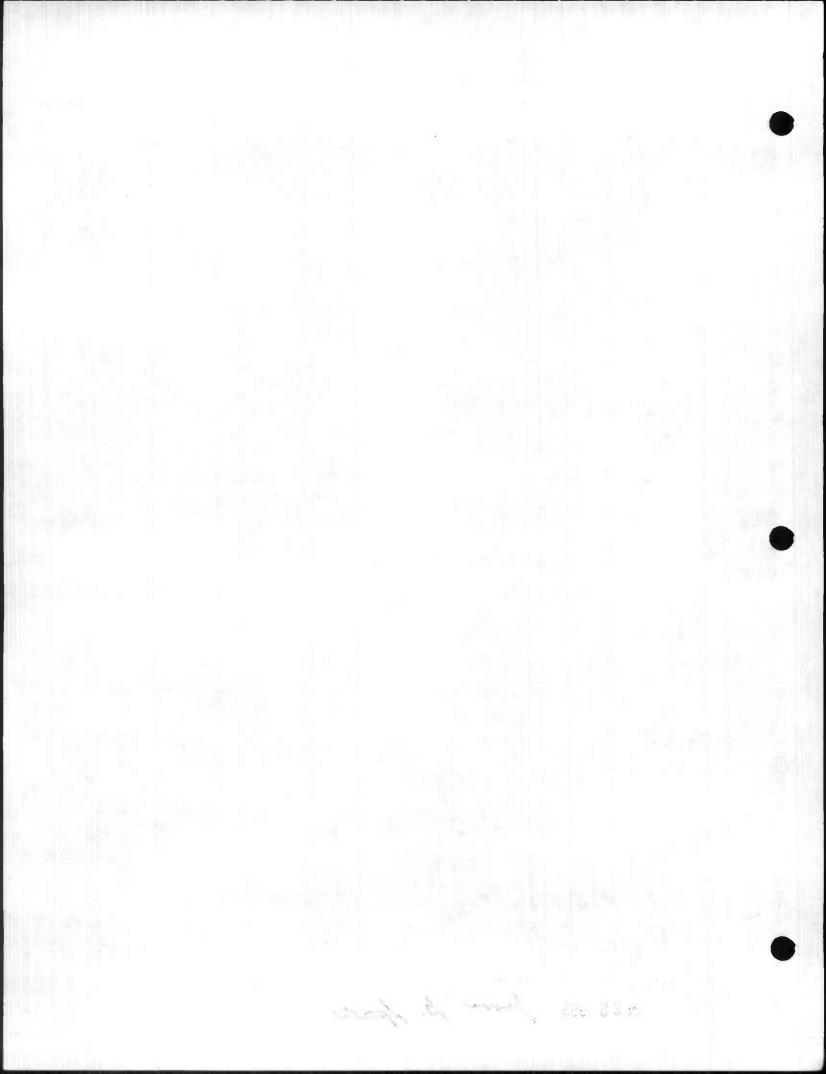
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State of Maryland / Department of Health and Mental Hygiene

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21. Signature of Forestal Services Licenses 22. Signature of Forestal Services 23. Part I. Enter the classes, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, process on each or medical interesting in death or control of the classes or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, process on each or control of the classes or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, process on each or control of the classes or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, process on each or control of the classes or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, process of the classes or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, process or each of the classes or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, process or each of the classes or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, process or each or combination of the classes or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, process or cardiac or respiratory errors. 23a. ADVANCED REFRACTORY OVARIAN CARCINOMA 4 / 97 24b. West as a consequence of): 25b. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical e	- Hara	1 XBurial 2 ☐ Cremetion		e cemeter	ry, cremetory o	r other ple							
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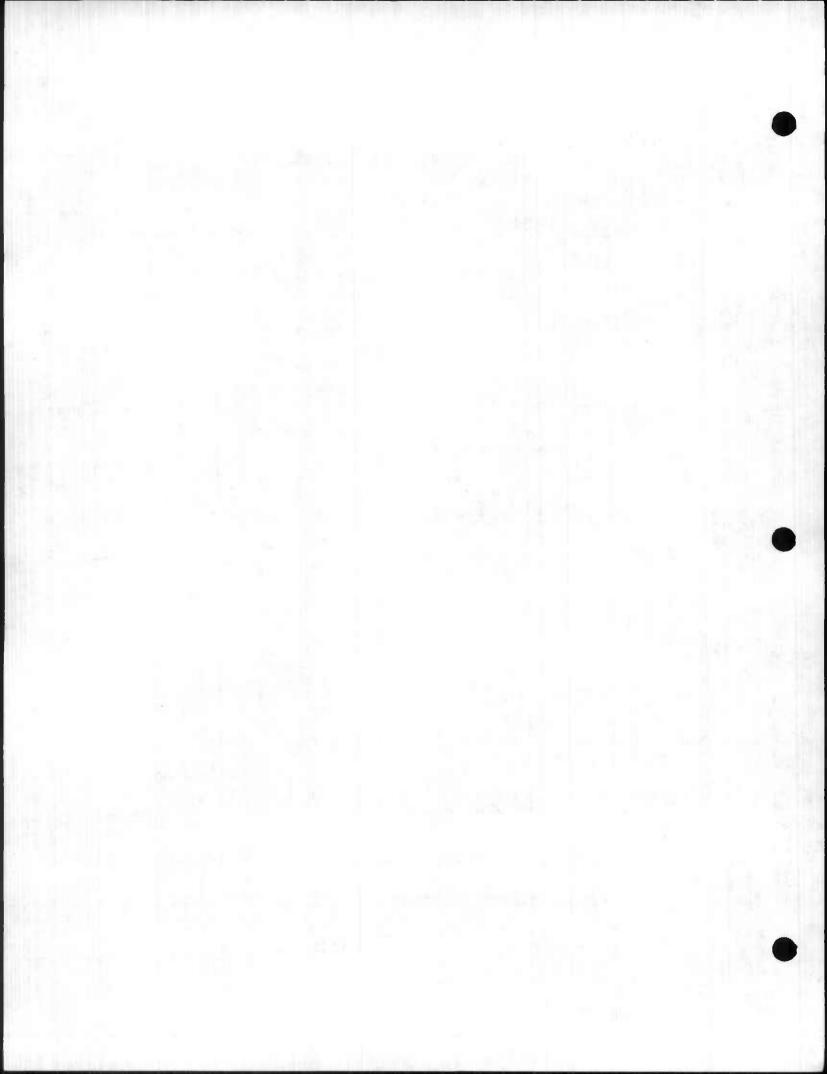


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State of Maryland / Department of Health and Mental Hygiene

				Certificate o	f Death	Re	g. No.	9 61010
Physician	1. Decedent's Nama (First, Middle, L.	est)				2. Date of Deat Month		3. Time of Death
Physician /Medical	Charles	Howard	На	rtman		JUNE 19	-	8:07A.M.
Examiner	4a Facility Nama (If not Institution, gi				4b. City, Town, or		4c. County o	
	Memorial Hospital 5. Social Security Number 6.			thday) If Under 1 Yes	Cumber 1			llegany
Funeral Director		Sex 7. Aga (Ir	n yrs. last bi	Yrs. Months Day		8. Date of Birth (Month, Day, Dec 24	, 1909	Birthplace (State or Foreign Country) MD
D Bu	10e. Stete 10b. County	. 10	c. City, Tow	n or Location				10d. Inside City Limits
the Maryla 28a-f sho notified at rector	MD Alle	egany		Cumberla	nd			1₩ Yes 2□No
vith the Ma t or 28e-f s be notified Director	10e. Street and Number	32		10f. Zip Code		11	0g. Citizen of W	het Country?
al Marie	346 Williams	Street			21502		USA	
her death v r hams 23a siner must Funeral	11. Marital Status	12. Was Decedant Eval Armed Forces?	r in U,S.	13. Wes Decedent o	f Hispanic Origin? (Suban, Mexican, Puert	pecify Yes or No-		- American Indian, , White, atc.
Dy by	1 Never Merried 2 Married 3 Wildowed 4 Divorced	Yes 2 No If Yes, Give Year or DetesWW	II	1□Yas Z□N				white
5-0 72 h mahum disali	15. Decedent's E (Specify only highest gr		16a	Decedent's Usuel Occ	upation ne during most of wor	rking	16b. Kind of Bus	iness/Industry
1 21215-0 led within 72 ho lygiens. Ner than "naturn It, the Medical. Completed	Elementery/Secondary (0-12)	College (1-4or 5+)		(Give kind of work dor life. DO NOT use reti	ired)		lino F	urniture Co
d 2.	12	41	Le	tired	I an adapt and bloom	me (First, Middle, M		
yland Mental H Mental H arked oth affic even To Be	17. Fathar's Name (First, Middle, Las Charles W. Haj	•			Matild		wigg)	
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, Marylan and 2 should be saith and Mental on 27 is marked core traumatic ever traumatic ever	19a. Informent's Neme/Reletionship Eileen McCoy	(Type, Pint)	12	615 Bowl	ing Stre	et;Cumb	erland	, MD 21502
Fe, N 1 and Health em 27	daughter 20a, Mether of Disposition	2	20b. Plece o	1 Disposition (Neme of		Date	20c. Location - 0	City or Town, State
Pages pant of lands ary or o	1 ABurial 2 Cremation 3 [4 Donation 5 Other (Special			ry, crametory or other p		6 (01 (a -1	13 4 100
mil. P partm pourtm y injur	21. Signetu/e of Funeral Service Lice		Sunse	t Memoria	rark Taspi Frune:			land, MD
B S S S S S S S S S S S S S S S S S S S	Malah	Marian	1):		land, Ma		21502	
	23a Pert1 Enter the disease or con	nolicetions that caused the	death Do			_		Approximate
Physician	23a. Pert1. Enter the disease, or conshock, or heart feilure. List only	one cause on each line.						Approximete Interval Between Onset and Deeth
/Medical	Immediate Cause (Final	AGUME MO	CADDI	AT THEADOW	OM			24 hours
Examiner	disease or condition resulting in death)	a .		AL INFARCT: consequence of):	LUN			
i i		Due	10 (01 03 0	consequence or,				
owscuted in and riel-transit	Sequentially list conditions,	bDue	to (or as e	consequence of):				
00, an an unation	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury							
box 68760, deeth certificate be executed to attending physician and of for use as the burial-transit sician/Medical Examir	that initiated events resulting in death) Last	C. Dua	to (or as a	consequence of):				
2 5 B 2		d						
Box seth cer attendir for use		0.						
4-U/-4923 Cords, P.O. Box requires that the deeth ca- been signed by the attendit should be detached for use leted by Physician/I	Part II. Other significant conditions	contributing to death but no	ot resulting i	n the underlying cause	given in Pert t.	-	/	tribute to the cause of death?
S, P.O. ss that the gned by the be detached by Phys		1 U Y	88 202No	3 Probably 4 Unknow				
ords, P.O. requires that the requires that the record of the point of the record of th						24a. Wes a	n autopsy	24b. Were autopsy findings
v requires should						perform	ned?	evailable prior to completion of cause of death?
I Records The law require The law seen signate has been signate has been signated by						400	s 2 No	1 Yas 2 No
	25 Was asso referred to medical	I			20 01-1-10	1 Ye		TLI Yas 25 No
	25. Was case referred to medical examiner?	Hospital:	2[] [[] [strations 20 DOA	Wher	eth (Check only on fome 5 ☐ Reside		(Specify)
Of Of Physical districtions of Tr. Tr. Tr. Tr. Tr. Tr. Tr. Tr. Tr. Tr.	27. Menger of Death	1 Inpatient 28a. Dete of Injury (Month, Day Ye		utpatient 3□ DOA ☐ Time of		28d. Describe ho	COLUMN TO STATE OF THE PARTY OF	***************************************
On On On On On On On On On On On On On O	1 Natural 5 Pending 2 Accident Invastigation		ear)		Vork? ☐ Yas 2 ☐ No			
KLES HAK! Division of Bio Attending P as after death. al Director: After t led in by the funers Certification:	3 Suicide 6 Could not I	28e. Place of Injury	At home, fa	arm, street, fectory, offic	xe xe			or or Rural Route Number,
Div Dive din by	4 Homicida	building, efc. (S	Specify)			City or Town	n, Stete)	
CHARLES Divi Divi Hospital or Att Puneral Direct Sel hours after of Funeral Direct stely filled in by		hysician: To the best of m						
2520 0	one)	miner: On the basis of exa end manner stated	ininetion ar					
To the common of	29b. Signature and title of certifier	QVN/		- Walter-	nse number	2	9d. Date signed	(Month, Day, Year)
6	,	0.		D	23371	J	une 21,	1999
JAK .	30. Name and address of person who Qamar U Zaman	M.D. 625	(Item 23a) Kent	(Type, Print) : Avenue (Cumberla	nd MD 2	1502	
State Registrar	31. Data filed (Month, Day, Year)	9 32 Alegistrar's	Signeture	9. Spork	1			

DHMH 16 Rev 6/95



Certificate of Death

2. Date of Death Month

Day

Year

cian dical		IAMS	HARTSC					4b. City, Town, o	June	26	County o	999	2:55 p.m
niner	te Facility Neme (If not ins MEMORIAL HOS		street and nur	noer)				CUMBERLA		PORTET 44G.			
31	5. Sociel Security Number 220–38–2471	6. Se	x JM 2[XF	7. Age (In yrs	: last birthday) Yrs.	If Under Months		If Under 24 Hr Hours Min	s. 8. Date of I				lace (State or Fore
-	Usuel Residence of Decede 10a, State 10b, C			10c. C	ity, Town or Lo	cation						1	0d. Inside City Limi
-		LEGANY	7										1 ☐ Yes 2 ☐ ↑
×	10e. Street and Number	LEGANI			FLINTST	10f. Zip	Code			10g. Citi	zen of W	hat Cour	try?
by Fur	11. Maritel Status 1 □ Never Married 2 □ 3 ☒ Widowed 4 □ Div) Merried	12. Wes Decs Armed Fo 1 Tes If Yes, Giv Year or De	2 🔯 No		Ves Deced i Yes, spec		lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or or or or or or or or or or or or or	No-	Bleck	e - American Indian, k, White, etc. WHITE	
- Annihimon	15. De (Specify only	cedent's Edu	cation		16a. Deced	lent's Usua	al Occup	nation during most of w	orkina	16b. Ki	nd of Bus	siness/Inc	dustry
1	Elementery/Secondary (0		College (1	-4or 5+)				during most of w d)					
-	0 17. Father's Neme (First, M	iddle Last)	_		HOME	MAKER	2	18. Mother's No	eme (First, Midd		ME M		
	JAMES WILLI								AKERS	20, 111010011	Comame	"	
1	19a. Informent's Neme/Rei		rpe, Print)		19b. Mallir	a Address	(Street	and Number or F		mber, City o	r Town, S	State, Zip	Code)
	JAMES HARTSO 20a. Method of Disposition 1>⊞Burial 2 □ Creme	Place of Dispo	719 MANGUM ROAD COLLEGE PARK of Disposition (Name of Dete				CK MA						
	4 □ Donetion 5 □ Otl				NSET CE	METER	RY .	JUNE 29	1999	CUMB	ERLA	ND M	ARYLAND
	21. Signeture of Funerel Service Licensee 22. Name end Address of Facility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYL.										YLAN	D	
cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		SEPS	Due to (or as a consequence or a consequence or a consequen	uence of):							lweek
	d										the cause of dear		
9													
Completed by Phy	CORONARY ART	ERY DI	24a. Was en autopsy performed? 24b. Were a evallable							ere autopsy findings allable prior to mpletion of cause			
												of	death?
	25. Wes case referred to m	odical									No	1[Yes 2 No
1	examiner?		lospitet:	nnatient 2	TER/Outnation	t 3□ DO	A Oth	vor:	Home 5 □ Be		s ∏Otha	r (Specif	v)
Sallolli.	27. Menyfer of Death 1 Venturel 5 Pending 2 Accident Accident Solution Injury (Month, Day Year) 1 Venturel 5 Pending 1 Venturel Solution Injury (Month, Day Year) 1 Venturel Solution Injury (Month, Day Year) 2 ER/Outpatient 3 DOA Venturel 3 DOA November 4 Nursing Home 5 Residence 6 Other (Sp. 28b. Time of Injury at Work? 1 Venturel Solution Injury Cocurred Work? 1 Venturel Solution Injury Cocurred November 1 Venturel S									,			
	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Ro City or Town, State)										I Route Number,		
Medical Certification:	29a. Certifier 1 Ce (Check only 2 Me one)	rtifying Phyr dical Exami	ner: On the ba and mann	sis of examine	owledge, death etion and/or inv	occurred a restigation,	at the tir , in my o	me, date and place pinion, death occ	ce, and due to the curred at the time	he cause(s) ne, dete and	and man d plece, a	nner as s nd due to	lated. the cause(s)
	29b. Signature and title of o	ortifier						e number					Day, Year)
1)332	280		Jun	129	,19	35
-	30. Name and address of pr		inpreted caus	e or death (ne	in Zoal (Type,	r may							
			62	25 KENT	AVE	CIME	ERT.	ND MARY	LAND 2	1502			
4	DR SUNIL I		IA .	25 KENT egistrar's Sign		CUMBI		AND MARY	LAND 2	1502			

with the ment from the front

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) June 20, 1999 **Physician** 10:30 a.m. Gale Leroy Hillegas /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner St. Vincent de Paul Nursing Center Frostburg Allegany If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (in yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 11, 1923 Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days 76 175-18-7018 Pennsylvania Director Usual Residence of Decedent the Marylend 10d. Inside City Limits 10e State 10c. City, Town or Location 10b County 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examinal must be notified at 1XXes 2□No Director Salisbury Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 133 Gay Street 15558 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) permit. Peges 1 and 2 should be filed within 72 hours after deat Department of Heelth and Mental Hygiene. Important: If them 27 is marked other them. 12. Was Decedent Ever In U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: Korea 1 ☐ Never Married 2 Married 1 Yes 2 No Specify: Specify. ρ 3 □ Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Commonwealth of PA, Elementery/Secondary (0-12) College (1-4or 5+) Maintenance man Somerset State Hospital 12 th 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Stanford Hillegas Elizabeth Holler 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane G. Hillegas/wife 133 Gay St., Box 273, Salisbury, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₩Burial 2 ☐ Cremation 3 ☐ Removal from State Salisbury Cem. June 22, 1999 Salisbury, PA 4 Donetion 5 Other (Specify) 21. Signature of Funeçal Serviçe Licensee 22. Name and Address of Facility Newman Funeral Home, Inc., P.O. Box 116 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heen failure. List only one cause on each line. Curran **Physician** /Medical Immediate Ceuse (Finel 3 weeks disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner ician end burial-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initioted events resulting in death) Lest Due to (or es a consequence of): P.O. Box 68760, physician Physician/Medicai eu the Due to (or es a consequence of): the 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings svailable prior to completion of cause 24a. Was an autopsy Completed peen 2 PNo 1 □ Yes 2 □ No certificate 1 Yes Division of Vital Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certific funeral director, Be 25. Was case referred to medicel exeminer? 26. Place of Death (Check only one) Other: 4 Uursing Home 5 Residence 8 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of Certification: 1-Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide 24 hours a 10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and piece, and due to the cause(s) end manner as steled.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical To the To the To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of certifier 133280 1999 30. Name and eddress of person who completed ceuse of death (item 23a) (Type, Print)

Sunil Gupta, M.D., 625 Kent Ave., Cumberland, MD

32. Registrar's Signature

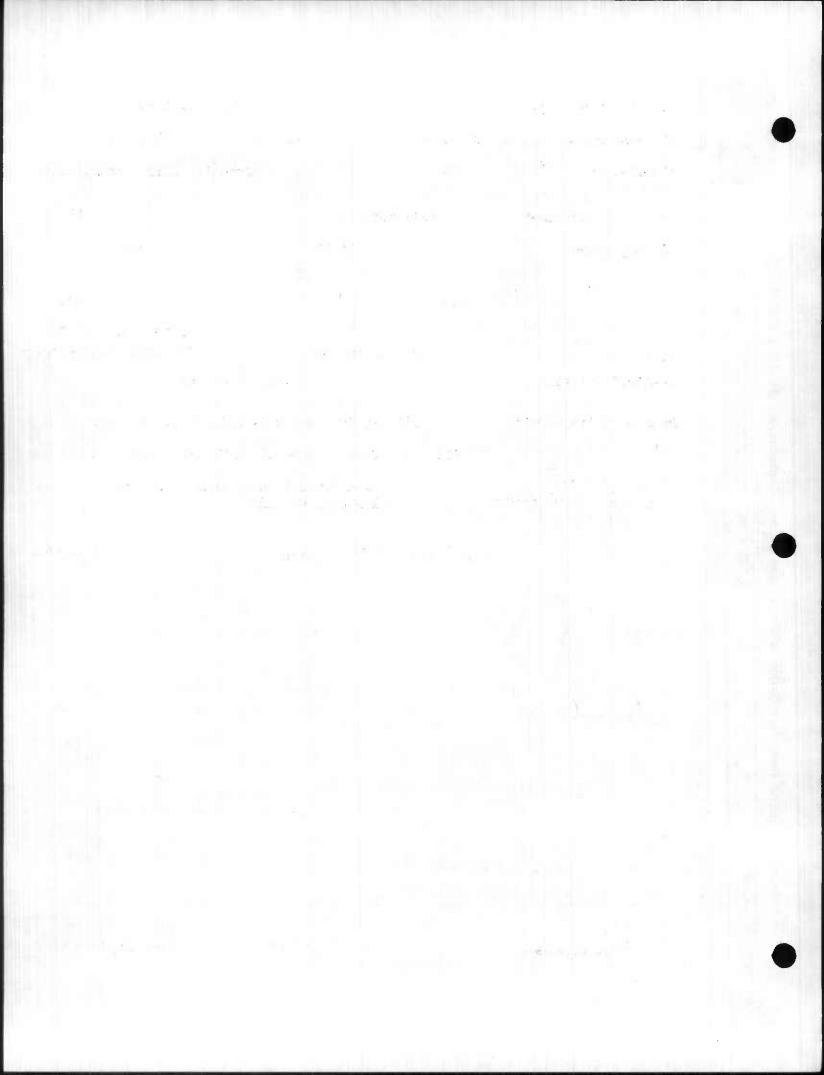
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Registrar

mis

State

31. Dete filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Mary		Certificate				Reg. No.) 2	1820					
П	Physici	an	Decedent's Neme (First, Middle, Last)						2. Dete of De Month	eth Dey	Year	3. Time of Deeth	1				
	/Medi		George Frederick Ha				_,_		06	28 1	999	2:35 PM					
	Examir	ner	4e. Facility Name (If not institution, give s	street end number)			4	4b. City, Town, or Lo	ocation of Deetl	4c. County	of Death						
			2024 Orchard Drive			- Mariana		Pocomoke			Worce						
ı	Funeral Director		223-28-7407	7. Age (In)		frs. Hunder 1 Y	eys	if Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, De 12/22/	h y, Year) 1913	9. Birthp Coun Viro	lace (Stete or Fore try) inia	iign				
	death with the Maryland ms 23a or 28a-f ehow		Usuel Residence of Decedant 10e. Stete 10b. County	10c.	City, Town	or Location					10d. inside City Limits						
	e Mai	ctor	MD Worcester	Po	comok	e City						1 A Yes 2 □ N	No				
	th the	rai Director	10e. Street end Number			10f. Zip Co	de			10g. Citizen of V	Whet Coun	try?					
	23a		2024 Orchard Drive			2185	1			US	A						
	er de	Funeral		12. Wes Decedent Ever i Armed Forces?	n U,S.	13. Was Decedent If Yes, specify	of H Cube	lispenic Orlgin? (Spen, Mexican, Puarto	ecify Yes or No Rican, etc.)	14. Rec Blee	e - Americ						
Maryland 21215-0020	be filed within 72 hours efter death with the Manylan stal hygiene. Idea other than "natural", or items 23s or 28s-4 show event, the Medical Examples crust be notified at	by F	1 Never Merried 2 Merried 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Yeer or Detes:39—				Specify:		Specify	" Whi	te					
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and	tal H	Be	17. Fether's Neme (First, Middle, Last)					18. Mother's Nemo		Meiden Suman	10)						
7	12 should be in and Mental is marked or reumatic eve	P	Clyde Thomas Hanco					Lula Bun									
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	1 and Health em 27 Ather tr		Evelyn W. Hancock 20e. Method of Disposition		b. Place of	24 Orchar Disposition (Name of	of		Dete CI	20c. Location -							
non	Pages nent of H ant: If ite		1 XBuriel 2 □ Cremetion 3 □ Re	emovel from Stete	cemeter	r, cremetory or other	r piec										
Baltimore,	교원관중 .		4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Fundrei Service License		ırst	Baptist C				Pocomok		.У , МО					
Ba	Depa impo any ic		21. Signeture of Fundrei Service Licensee 22. Name end Address of Fecility Holloway-Melson Fund 103 Linden Ave., Pool							III and the second		351					
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	d d ansit	Examiner	b.	CORONA		onsequence of):	<i>y</i>	DISE	ASE		7.	20 YEAR	25				
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2	Physician: this certific	To	examiner? 1 XYes 2 No	ospitei: 1 🗆 Inpatient 🥻	ER/Out	patient 3 DOA	Oth				er (Specif))					
0	ding Ph th. After th funeral		27. Menner of Death 1 Neturel 5 Pending	28a. Date of Injury (Month, Dey Year	28b. Ti	me of 28c.	Injun Worl	y et k?	28d. Describe I	now injury occur	red						
SIO	Attendition of the function of	cati	2 Accident Investigation			М		Yes 2□No									
Division of	8 E E C	ertification:	3 Suicide 6 Could not be determined 28a. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify)							Street and Numb vn, Stete)	er or Rura	Route Number,					
	To the Hospital of within 24 hours all To the Funeral D completely filled it	edicai C	(Check only 25 Medical Examine	ctan: To the best of my ler: On the basis of exem	nowledge, inetion end	death occurred et th	ne tim	ne, dete and place, pinion, deeth occurr	and due to tha ed et the time,	cause(s) and me data end place,	nner as st	eted. the cause(s)					
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						16241											
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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ı	Physician /Medical									Day Year		Year	40 PM	
P)	Examiner	4a Facility Name (If not instituti		Location of Death 4c. County of Death										
		ALLEGANY CO NURSING HOME CUMBERL 5 Social Security Number 6 Sex 7 Age (In vrs. last hirthday) If Under 1 Year If Under 24 Hrs.											ANY	
l	Funeral Director	5. Social Security Number 217–10–1303	6. Sex 1 □ M 2X F	7. Age (In yrs 88	. last birthday) Yrs.	Months	Days	If Under 24 H	lin. 8. Date of E (Month, I MARCH	Birth Day, Year 8 1	y, Year) 9. Birthpl Count MARYI			
H	pue *	Usual Residence of Decedent 10a. State 10b. Count	ty	10c. C	ity, Town or Lo	cation						10d, In	side City Limits	
	deeth with the Maryland ima 23a or 28a-f show imat be notified at neral Director	MARYLAND ALLI	EGANY	C	LDTOWN					1				
	or 20	10e. Streef end Number				10f. Zip				10g. C		What Country?		
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21	E	Elementery/Secondary (0-12)		(1-4or 5+)	life. L	OO NOT us	e retired)	HOINING					
	filed wit Hygiene ther the	11		HOME MAKER 18. Mother's Nem								MAKER		
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χie γ	Ner Mer									NCE JORDAN				
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	f Health frem 27 other tr	20a. Method of Disposition	DE		Place of Dispos			O · BOIL	Date			- City or Town, S		
altimore,	ages ent of nt: if it	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Cieta	SE HILL	netory or of	ther pled					AND MARY		
Ball	permit. Pa Departmen Important: eny injury .	21. Send re of Funeral Service	· Wern	tt	ME	RRITT	-ADA		ERAL HOM			YLAND		
		23a. Part1. Enter the diseese, or heart feilure. Lis	or complications thet st only one cause on	caused the dee	th. Do not ente	er the mode	e of dyln	g, such as cere	diac or respiratory	arrest,		Inter	oximate val Between et and Death	
	Physician /Medicai	Immediate Cause (Final										Olisi	et and Death	
	Examiner	disease or condition resulting in death)	a Ur	O Seco	vin-							2	CHAD	
	<u> </u>			Due to	or as a conseq	uence of):								
	be executed sician and burial-transit		b	Due to (or as a consequence of):										
o n	executed in and rial-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury		See to far as a consequence ory.										
760,	0 20 0	that initiated events	С	CDue to (or as a consequence of):										
ox 68	The law requires that the deeth certificate tate has been signed by the attending physicage 2 should be detached for use as the Completed by Physician/Medics	resulting In deeth) Lest	d			,								
0	deeth e atten ed for u	Decision Colorado de Calendari	it and a second second	double but a star				i- D-d I	225 0	ld tabass		ontributa to the	name of death	
0	ed by the detached	Pert II. Other significant condit	0		suiting in the ur	idenying ce	euse giv	en in Pan I.		☐ Yes	2 No		4 Unknow	
S, P	that ned be determined by	Neutrosc	leson						_ ''		292110	O I TTO GALLY		
rds	w requires that been signed I should be det	Men D F	0						24a. W	as an au	lopsy		utopsy findings	
Vital Record	w rec	Venal 1	- as luy						_ pe	rformed?			ion of cause	
Be	cate has to page 2 s								11	Yes	2 V No	1 □ Yas	-	
la	certificate rector, pag	25. Was case referred to medic	eal .					26 Place of	Death (Check on		200	10100	29010	
>	Physician: this certific ral director,	examiner?	Hospital:	inpatient 2	☐ ER/Outpetien	t 3 DO	Oth	er.	g Home 5 □ Re		6 Ott	her (Snecify)		
	Phys eral di enal di	27. Manner of Death	28e. Dete	of Injury	28b. Time of		8c. Injur	y et	28d. Describ					
E	tal or Attending Ph rs after death. of Director: After th ed in by the funeral Certification:	1 Naturel 5 Pend 2 Accident Inves	ling (Mo	nth, Dey Yeer)	Injury	М	Wor	Yes 2 □ No						
Division				28e. Place of Injury - At home, farm, streef, factory, office building, etc. (Specify)					1	281. Location (Street end Number or Rurel Route Number, City or Town, Stete)				

2 nes

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. R. BARRERA MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND MARYLAND 21502

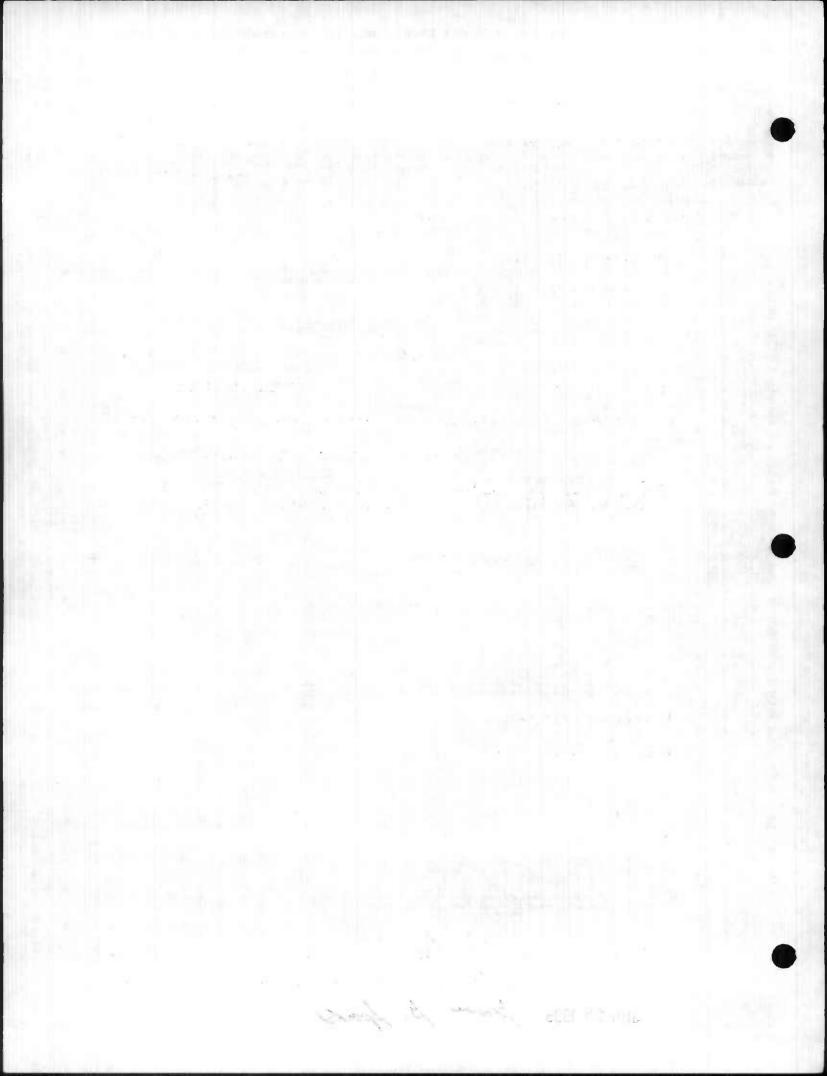
31. Date filed (Month, Day, Year)

JUN 2 9 1999

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)



Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day Month Veer Clifton Benjamin Jackson 24 1999 8:30am June 4c. County of Death 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Havre de Grace H If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 118 Anderson Avenue Harford Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) 6 Sex 10XM 2□F Months Days Yrs. 91 232-05-5111 07/21/1907 West Virginia Usuel Residence of Deceden 10c City Town or Location 10d. Inside City Limits 10e State 10h Counts 1 Yes 2 □ No Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 118 Anderson Avenue USA 12. Was Decedent Ever in U,S. Armed Forces? 1 XYes 2 No If Yes, Give Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, 11 Meritel Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced WW 2 Yeer or Detes: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 6th Carpenter Construction 18. Mother's Name (First, Middle, Meiden Sumame) 17. Fether's Neme (First, Middle, Last) William Clay Jackson Fannie Alice Lewis 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 118 Anderson Ave., Havre de Grace, MD 21078 ce of Disposition (Neme of Dete 20c. Location - City or Town, State Ruth Mauldin- Daughter 20e. Method of Disposition 1 2 Bunel 2 Cremetion 3 Removal from Stete 20b. Place of Disposition (Neme of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Angel Hill Cemetery 6/28/99 Havre de Grace, MD 22. Name and Address of Fecility Mitchell-Smith Funeral Home, P.A. 21. Signeture of Funeral Service Licenses 123 S. Washington, Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, sheek, or heart failure. List only one ceuse on each line. Approximate Interval Betwee Onset end De Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveileble prior to completion of cause of death? 24e. Wes en autopsy performed? 1□ Yes 2 No 1 Yes No 25. Was cese referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 | Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

certificate be executed physician and the bunal-trans P.O. Box 68760 signed by the aid be detached for Division of Vital Records, paga 2 s or Attending Physician: funaral director, this Aftar

Physician

/Medical

Examiner

Director

Funeral

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7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at

permit. Pagas 1 and 2 should be filed within 72 hours attar c. Department of Health and Mental Hygiena. Important: if item 27 is marked other than "naturel", or item eny injury or other traumatic event, the Medical Enarcements.

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Certification: To

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29e. Certifier

29b. Signeture and

Baltimore, Maryland 21215-0020

the Maryland

death

hours after death. complately filled in by Hospital c
 24 hours a
 Funeral D within 2 To the F 3

State

-ous Silverstein 31. Date filed (Month, Dey, Year)

30. Name and address of person

8055. 32. Registrar's Signature

who completed ceuse of death (Item 23a) (Type, Print)

HAURE de GrACE, MD 21078 inion Ave

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

29d. Dete signed (Month, Day, Year)

Registrar



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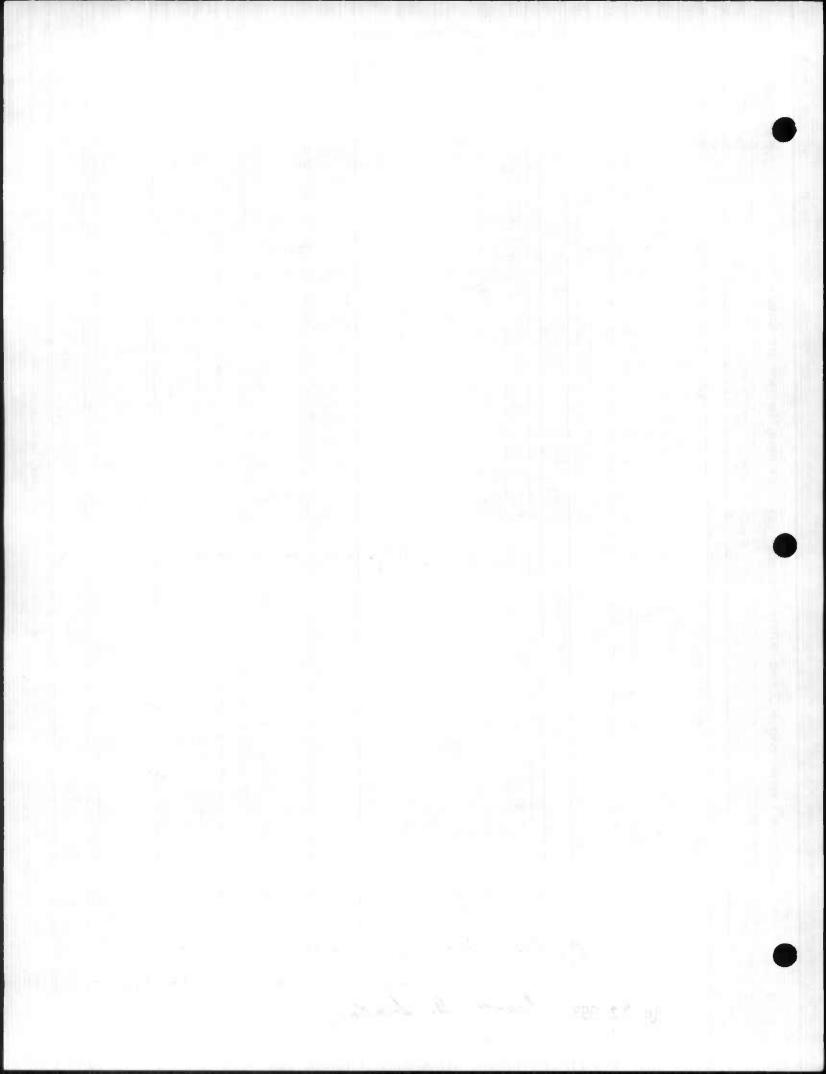
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Day 999 Year Jul 1, **Physician** Millie Louise Jewell 08:10pm /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number) Examiner Devlin Manor Nursing Home Cumberland Allegany Hours Min. 8. Dete of Birth Month, Dev, Year 1920 Birthpiece (State or Foreign Country). 7. Age (In yrs. last birthdey) If Under 1 Year Months Days 5. Social Security Number 6. Sex **Funeral** Days 1 ☐ M 2 😿 F 215-12-2126 79 Director Usuei Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. and if them 23 a or 28=4 show ant: If them 27 is marked other than "natural", or items 23a or 28=4 show ant: If them 27 is marked other than "natural", or other traumatic event, ins Medical Espatiner man be notified at ury or other traumatic event, ins Medical Espatiner man be notified at 10e. Stete 10b. County 10c. City, Town or Location 10d, toside City Limits 1 Yes 2 No Allegany Directo Cresaptown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 12830 McKay Avenue SW 21502 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces 1 Yes, 2 No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🌪 ☐ No Specify: Baltimore, Maryland 21215-0020 Specify: white by Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Retired Manager Restaurant 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) (Lombard) James Pratt Nellie 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 12828 McKay Ave SW; Cresaptown, MD 21502 19a. Informent's Neme/Reletionship (Type, Print)
Katherine Jewell daughter-in-law 20a. Method of Disposition 20b. Piece of Disposition (Neme of cametery, cremetory or other piece) Dete 20c. Location - City or Town, Stete 1 Buriai 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If any injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) Hillcrest Memorial Par7/06/ Cumberland, MD 21. Signeture of Funerei Service Licenses 25 tarpéisifruneral Home P.A. Cumberland, Maryland 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feiture. List only one cause on each line. **Physician** /Medical Immediete Cause (Finel diseese or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed physician and s the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequenca of): 60 use for signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown g 24b. Were autopsy findings evallable prior to completion of cause of deeth? been si Completed 24a. Wes en eutopsy performed? s cartificate has b director, page 2 s 1 Yes 2 No 1 □ Yes 2 □ No or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Neturei 5 Pending aftar death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 1 24 hours after decidence in Funeral Director pletaly filled in by the 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Lactifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) and manner es stated. 29a. Certifier edical To the Hosp within 24 hor To the Fune completaly fi (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signeture end title of certifier llow mis 1017565 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) mes AJ Pollino 626212 20 1-2+1 921 32. Registrer's Signature 31. Dete filed (Month, Dey, Year) State 0 2 1999 Registrar

DHMH 16 Rav 6/95



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State of Maryland / Department of Health and Mental Hygiene 99 21821

			Certifi	icate of	Death	F	Reg. No.	61064				
	Dhamiaia	Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th Day Yea	3. Tima of Death				
	Physiciar /Medica	Jonathan Robert Jenkins				JUNE	30 1999					
	Examine	4a Facility Name (If not institution, give street and number)			tb. City, Town, or Lo	cation of Death	4c. County of D	aath				
		Sacred Heart Hospital	Allegany									
н	Funeral	5. Social Security Number 6. Sex 7. Age (In	I yra. mat ombrody/	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. l	Birthplace (State or Foreign Country)				
	Director	220-16-6434 73 Usual Residence of Decedent	1			17-Jun-2	Mc Mc	aryland				
	ahow ad a	10a. State 10b. County 10c. City, Town or Location										
	Mar	Maryland Allegany Fr	ostburg					1 Yes 2 No				
	or 28a-f a	10e. Street and Number		Of. Zip Code			10g. Citizen of What	Country?				
	23a	45 West Main Street		21532-								
	72 hours after death with the Maryland natural; or items 23s or 28s-f show size Examiner must be notified at least by Ermanel Disaster.	11. Marital Status 12. Was Decedent Ever Armed Forces?	r in U,S. 13. Was	Decedent of H	lispanic Origin? (Span, Mexican, Puerto	cify Yes or No- Rican, etc.)	U.S.A. 14. Race - A Black, W	merican Indian, /hite, etc.				
20	aft, or h		10	Yes 2 No	Specify:		Specify:					
21215-0020	"natural",		16a. Decedent	'a Haust Ossur	ation		16b. Kind of Busine					
15	E	15, Decedent's Education (Specify only highest grade completed)	(Give kind	of work done	during most of worki	ng	TOO. KING OF BUSINE	Samuusiiy				
212	filed within Hygiens.	Elementary/Secondary (0-12) College (1-4or 5+)		Director			and Develop	er				
	be filled that Hygid d other present, p	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle,	Maiden Sumame)					
Vai	should be filed nd Mental Hygi i marked other umatic event,	William E. Jenkins			Bessle Sleen	nan						
Maryland	2 6 4 2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Ad	ddress (Street	and Number or Rura	I Route Numbe	r, City or Town, Stat	e, Zip Code)				
	r Health tem 27 other tr	Joan Jenkins Wife	45 West Main	Street	Frostt		Maryland	21532-				
Baltimore	20 10 10	1 kg burial 2 Li Cremation 3 Li Removal from State	20b. Place of Disposition cometery, cremato			Date	20c. Location - City					
tim			Frostburg Memo			-Jul-99 F	rostburg, Mo	ıryland				
Bal	Departr Departr Importa eny Inje	21. Signature of Funeral Service License		ame and Addre		rort Ave	Frostburg, M	D 21532				
		23a Paul Finter the disease or complications that caused the						Approximate				
	Physician	23a. Part LEnter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.						Interval Between Onset and Death				
	/Medical	Immediate Cause (Final	0/0/0	001 0	02 (.).	11.0.0	0.0	Danel-				
1	Examiner	disease or condition resulting in death)	to (or as a consequent	ce of):	esnia	Hear	Jonas	x sovey				
L.	D 4 5		bigata	76	or lu.	1 0		6 week				
	n and fairtraneit	Sequentially list conditions,	o (or as a consequent	ce (f):	WCV-	0	0	1				
60,		Cause (Disease or injury	Il Clar	Prese	on.	dint	7505					
68760	physical party of the state		to (or as a consequence	ce of):								
0.00	£ 2. 2	d. D.C.	abete) -								
Box	e attend e for us	Part II. Other significant conditions contributing to death but no		A data a source at	na in Donat	non Dida	abassa usa sastrib	ude to the cours of death?				
o	6 66 2	Part II. Other significant containing to death but the	A resulting in the under	rywig cause giv	en in carti.	1 0		Probably 4 Unknown				
ď,	£ 80 >	11/087100					100 April 02	J. Foodbiy				
Records,		50 500	Mascul	7-	0.0000		an autopsy 24	lb. Were autopsy findings available prior to				
00		- Occuration	WASCUX	ma	Mense	pano		completion of cause of death?				
č	The lay site has page 2	de C.E.				101	es 20 No	1 Yes 2 No				
Vital	certificate rector, pag	25. Was case referred to medical examiner?			26. Place of Death	(Check only o	ne)					
2	Physician; this certific ral director, To Be	1 Yes 20 No Hospital: 16 Inpatient	2 ER/Outpatient 3	3 DOA Oth	er: 4 Nursing Ho	me 5 Resid	lence 6 Other (5	Specify)				
-	After the funeral fune	27. Manner of Death 1 Notural 5 Pending 28a. Date of Injury (Month, Day Ye		28c. Injur Wor		28d. Describe h	now injury occurred					
sio	Attending r death. setor: Afte by the tune	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 No	not I continu /6	Need and Numbers	Duni Dauta Number				
Division of	P442	4 Homicide determined 286. Place of injury building, etc. (S	At home, farm, street, specify)	ractory, onica		City or Tow	m, State)	r Rural Route Number,				
-	# # 2 2 E	29a. Certifier 12 Certifying Physician: To the best of m	v knowledge, death occ	curred at the tir	ne, date and place	and due to the	cause(s) and manne	r as stated				
	n 24 hou in 24 hou he Funer pletely fil adlical	(Check only 2 Medical Examiner: On the basis of examiner and manner stated.	mination and/or investig	igation, in my o	pinion, death occurr	ed at the time,	date and place, and	due to tha cause(s)				
	within 24 I within 24 I To the Fu completel	29b. Signature and the of certifier		29c. Licens	e number		29d. Date signed (M	onth, Day, Year)				
		John Motean	110 44	1 >-	1752	6 9	June, 3	0,1999				
	w	30. Name and address of person who completed cause of death	(Item 23a) (Type, Print	0 0	1 1	- 10						
	6	John Mehanna M.D. 9023	don Drive	Lumb	perland,	MD o	21502					
	State	31. Date filed (Month, Day, Year) 32. Heginter's										
	Registrar	JUL 02 1999	we b.	do	1.1							

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Maryland Aleadon Fostburg

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ASSUMPTIONS From Prostage Menyland 21332 andres noot

Poursor J. Merico of Fan 03-Jul-99 Frostburg, Maryland

Direct Funeral Hame, 57 frost Avo., frostpurg. MD 21533

	State of Maryland / Department of Health and M Certificate of Death		Reg. No.	, 2	1825
Physician /Medical	Decedent's Name (First, Middle, Last) George William Kerns	2. Data of De Month JUNE	Day	Year 999	3. Time of Death 9:00 PM
Examiner	4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Lo	cation of Death			
Funeral Director	Sacred Heart Hospital 5. Social Security Number 6. Sex 150 M 2 F 7. Aga (In yrs. last birthday) 7. Aga (In yrs. last birthday) 7. Aga (In yrs. last birthday) 7. Aga (In yrs. last birthday) 7. Aga (In yrs. last birthday) 7. Aga (In yrs. last birthday) 8. Hours Min.	8. Data of Biri (Month, Da			ace (State or Foreign ny) and
2 .	Usual Residence of Decedent				
fenylen stat	10a. Stata 10b. County 10c. City, Town or Location			10	d. Inside City Limits 1 ☑ Yas 2 ☐ No
vith the Mer t or 2844 s be notified	Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code		10g. Citizen of W	hat Count	
eth w	21532-		U.S.A.		
within 72 hours after deeth with the Meryland enemeral, or items 23s or 28s-f show he Medical Exercises court be notified at employed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forcas? 1 Navar Marriad 2 Amarriad 1 Marriad 1 Marriad 2 No If Yas, Giva Year or Dates: W W 1	city Yas or No Rican, atc.)	Specify:		
natural',	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Bu	nite siness/Indi	ustry
2 should be filed within 72 hours at and Mental Hygiene than "natural", or summit event, the Medical Estation To Be Completed by F	(Specify only highest grade completed) Elemantery/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+)	ng	textile man		
filled Hygid ent, n	17. Fathar's Name (First, Middle, Last) 18. Mother's Nama	(First, Middle,			1.5
s 1 and 2 should be filed with Health and Mental Hypiens. Item 27 is marked other ther other traumatic event, the in	George E. Kems Anna Folk				
d 2 should be file d 2 should be file th and Mental Hy 7 is marked othe traumatic event	19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rura	i Route Numbe	er, City or Town,	State, Zip	Code)
D = 7.5	Evelyn Kems Wife 197 Welsh Hill Frost	bura	Marylan	d 21	532-
oemit. Pages 1 end Pepartment of Health important: if Item 27 ny Injury or other ti MGs.	20a. Mathod of Disposition 20b. Place of Disposition (Name of	Date	20c. Location -		
nit. Pages artment of l ortant: If he Injury or o	1	3-Jul-99	LaVale, M	arylan	d
permit. Pag Department Important: h any Injury o	21. Signature of Funaral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 F				
	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of nock, or heart failure. List only one cause on each line.	or respiratory a	rrest,	-	Approximate Interval Between
Physician /Medical Examiner	Immediata Ceusa (Final disaasa or condition CARDTO PIII.MONARY ARREST			1	Onset and Death unknown
	rasulting in death) Dua to (or as a consequence of):			- 1	
a si g	PANCREATIC CANCER/CHOLANGIO CANC	CER		1	ınknown
cate be executed physician and the burial-transit dical Examiner	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Oisaase or Injury c.				
eath certificate be ex attending physician for use as the burial clar/Medical E.	that initiated events resulting in death) Last Due to (or as a consequence of):			1	
death certifie attending of for use as	Post II Other classificant conditions and the conditions and the conditions are conditions as a condition of the conditions and the conditions are conditions as a condition of the condition of the conditions are conditions as a condition of the	l con pud	A-b	1	the course of death;
that the ed by th detach	Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.			3 Prob	the cause of death'
The taw requiras the taw requiras the tast been signe page 2 should be completed by			an autopsy ormed?	con	re autopsy lindings ilable prior to apletion of cause eath?
The law ate hes page 2		10	Yes 2 No	1	Yas 2□ No
delen: The certificate rector, pa	25. Was casa referred to medical 26. Place of Death	(Check only o	one)		
	examiner? 1 Yas 2 No Hospital: Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor	ma 5 Resi	dence 6 Othe	er (Specify)
Attending Physical death. Sector: After this by the funeral d	1 XNatural 5 Pending (Month, Dey Year) Injury Work? 2 Accident Invastigation M 1 Yes 2 No	28d. Describe	how injury occurr	ed	
tal or Attanding P rs after death. al Director: After t led in by the funer Certification:	3 ☐ Suicida 6 ☐ Could not be datarmined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)	28f. Location (: City or To	Street and Numbers, State)	er or Rural	Route Number,
he Hospi in 24 hou he Funer pletaly fill edical	29a. Certifiar (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, a constant of the control				
	29b. Signetura and titla of certifier Planam + Cr. Hill 29c. License number Cara H0053855		JULY	1,19	
(114) (6	30. Name and address of person who complated causa of death (Item 23a) (Type, Print)	21502			
State Registrar	31. Data filed (Month, Day, Year) JUL 72 1999 32. Registra's Signatura	II-			

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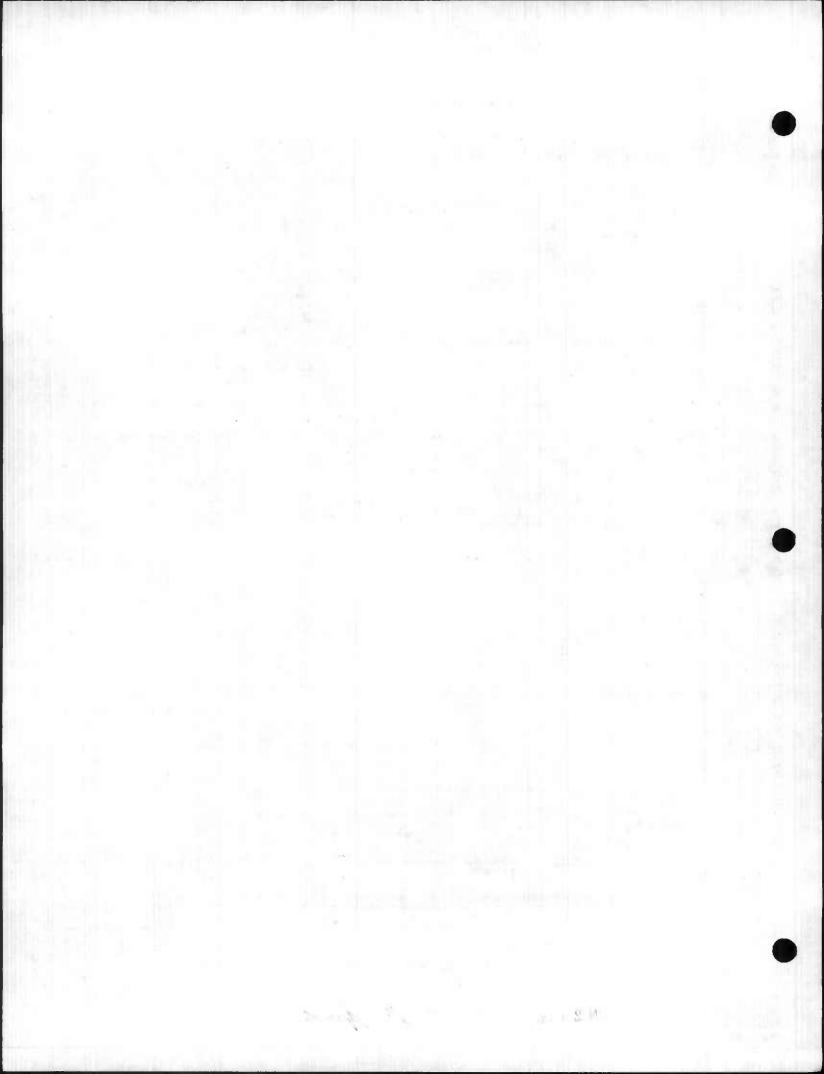
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month TUNE 10 **Physician** ANNA, L KEZLEN BENZ

4a Facility Name (If not institution, give street and number) ANNA 12 06 1999 23 /Medical 4h. City. Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MANYLAND 3ALTIMONE Hours Min. April 26 1915 Md 9. Birthplace (State or Foreign ff Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□M 200F Months 84 213-30-8957 Director Usual Residence of Decedent 10c. City, Town or Location Ellicott City 10d. Inside City Limits r than "natural", or flems 23a or 28a-f show the Medical Examiner must be notified at Howard 1 ☐ Yas 2 No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10206 Maxine Street 21042 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas ②ÛNo Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 ahould be filed within 72 hours after to Department of Health and Mental Hygiens. Insportant: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Exemination. 1 ☐ Never Married 2 ☐ Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) medical records clerk health care 17. Father's Nama (First, Middle, Last) Middleton Lee King 18. Mothar's Nama (First, Middle, Maiden Sumama) Susie Hendricks 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Anthony (daughter) 10206 Maxine St., Ellicott City, MD 21042 20b. Place of Disposition (Nama of 20c. Location - City or Town, Steta 20a. Mathod of Disposition St. John's Cemetery 1 Burial 2 Cremation 3 Removal from State 6-26-99 Ellicott City, Md 4 Donation 5 Other (Specify) 22. Nama and Addrass of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service License rean P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Stroke 3 days disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physicien and the burlai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yas 2 2 No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this cartification of the funeral director; After the funeral director; It is a second to the funeral director; It is a second to the funeral director; It is a second to the funeral director; It is a second to the funeral director; It is a second to the funeral director; It is a second to the funeral director; It is a second to the funeral director; It is a second to the funeral director; It is a second to the funeral director; It is a second to the funeral director; It is a second to the funeral director; It is a second to the funeral director; It is a second to the funeral director dire 8 25. Was case referred to medicat axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 1 Naturat 5 Pending 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At homa, 1arm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide edical 29a. Certifier 🖄 Certifying Physician: To tha best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier layed yeleta P11515 June 23, 1999 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MARKAND 21201 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State JUN 2 4 1999 Registrar



Registrar

State

111 Penn Street, Baltimore, Maryland 21201

address of person who completed cause of death (Hem 23a) (Type, Print)

32. Registrar's Signature

Year)

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	Physician (Medical	Leo Vin	cent Mi	ller			June			5:30 P.M.	
	/Medical Examiner	4a Facility Name (If not institution, giva	street and number)			4b. City, Town, or I.	A				
	*	Memorial Hospita	il			Cumber	land	Al	Legany		
	Funeral	5. Social Security Number 6. Se		. last birthday)	If Under 1 Yea	r If Under 24 Hrs.				ce (State or Foreign	
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	Man M	10a. Stata 10b. County	10c. C	ity, Town or Lo	cation				100	d. Inside City Limits	
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	vith the Ma t or 28s-f s be notified Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country	v?	
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	ther death with the Maryland r thems 23e or 28e-f show inner must be notified at Funeral Director	11. Marital Status	12 Was Decedent Ever in I	U.S. 13. V			pacify Yas or No-		ce - Americar	Indian.	
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20	Mr. or		If Yes, Give Yaar or Dates:		I□Yes 2Ò No	Specify:		Specif	. Whi	te	
5			THE PERSONS	16a Decer	lent's Usuel Occi	mation		16b. Kind of B	usiness/Indu	etry	
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7	The party	Elementary/Secondary (0-12)	College (1-4or 5+)		lechanic			Auto R	epair		
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a	Be ever	Samuel Guy Mil	ler				Susan				
2	To To										
N	12 st la en la en	19a. Informant's Name/Relationship (7		7.7	e in the contract	et and Number or Ru					
· ·	and m 27	Mahala S. Miller				Lane Lot 7					
5	2 0 m 7	20a. Method of Disposition 1 Derial 2 Cremation 3 D	Ramoval from State	cemetery, cren	sition (Name of natory or other pl	ace)		11 v 1			
Ē	Page 1	4 Donation 5 Other (Specify,	H	orner C	emetery		1999	Stoyst	own, F	A	
8	Party Pourty	21. Signature of Funeral Service Licens	500	22	. Name and Addi	ress of Facility Hau	ger-Zei	oler Fu	neral	Home	
۵	89228	& Lucard K	Luxer	1	01 W. M:	ain Street	Somers	et PA	15501	1101110	
	Physician /Medical Examiner	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	· Mul		- Inju				; 1	Approximate Interval Between Onset and Death	
0,0070	certificate be executed adminished by the purishment and use as the burial-transit and the control of the contr	Sequentially list conditions, if any, leading to immediate cause. Entar Undertying Causa (Disease or Injury that initiated events resulting in death) Last	c	or as a conseq					\$ 8 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
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	ist the death ceid by the attendireteched for use	Part II. Other significant conditions co	ntributing to death but not re	sulting in the ur	nderlying causa g	iven in Part I.	23b. Did t	obacco use co	ontribute to t	he cause of death'	
	Phy t						101	res 2 No	3 Probe	bly Minknow	
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STOCK OF THE STOCK	been s should should							an autopsy med?	com	e autopsy findings lable prior to pletion of ceuse eath?	
	iction: The lay certificate has rector, page 2 be Comp						nzh	°es 2□No	FOX	Yes 2□ No	
	in: T	25. Was case referred to medical				Of Place of Dag				100 2010	
>	sicia cert lirect	axaminer?	Hospital:	D CD40-4-4i	0 200	ther	th (Check only o		(0it-)		
5	Physician: this certific and director, TO Be	27. Manner of Death		28b. Time of	3LI DOA	4 Li Nursing H	ome 5 Resid			1	
=	D ST O	1 Naturat 5 Panding investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	200		Yes 2 No	motorco	jeli ac	ciden		
2	To the Hooptial or Attending P within 24 hours sher death to the Funeral Director. After toompletely filled in by the funeral Medical Certification:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, form, sylving)	bet, fectory, office		1	itreet and Num. m. State) Rt	96 0	Routa Number,	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Ceri	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	reician: To the best of my kn iner: On the besis of examin and menner stated.	owledge, death ation and/or inv	occurred at the restigation, in my	time, date and place, opinion, death occur	and due to the	cause(s) and m	enner as stat	ted.	
	Within on the comp	29b. Signatura and title of certifier	001		29c. Licer	nse number		29d. Date signe	ed (Month, Di	ay, Year)	
	/2	bleum	- L'Chutero		0	.C.M.E.		June 27	, 1999)	

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Registrar

30. Name and address of person who completed cause of deeth (ttem 23a) (Type, Print)

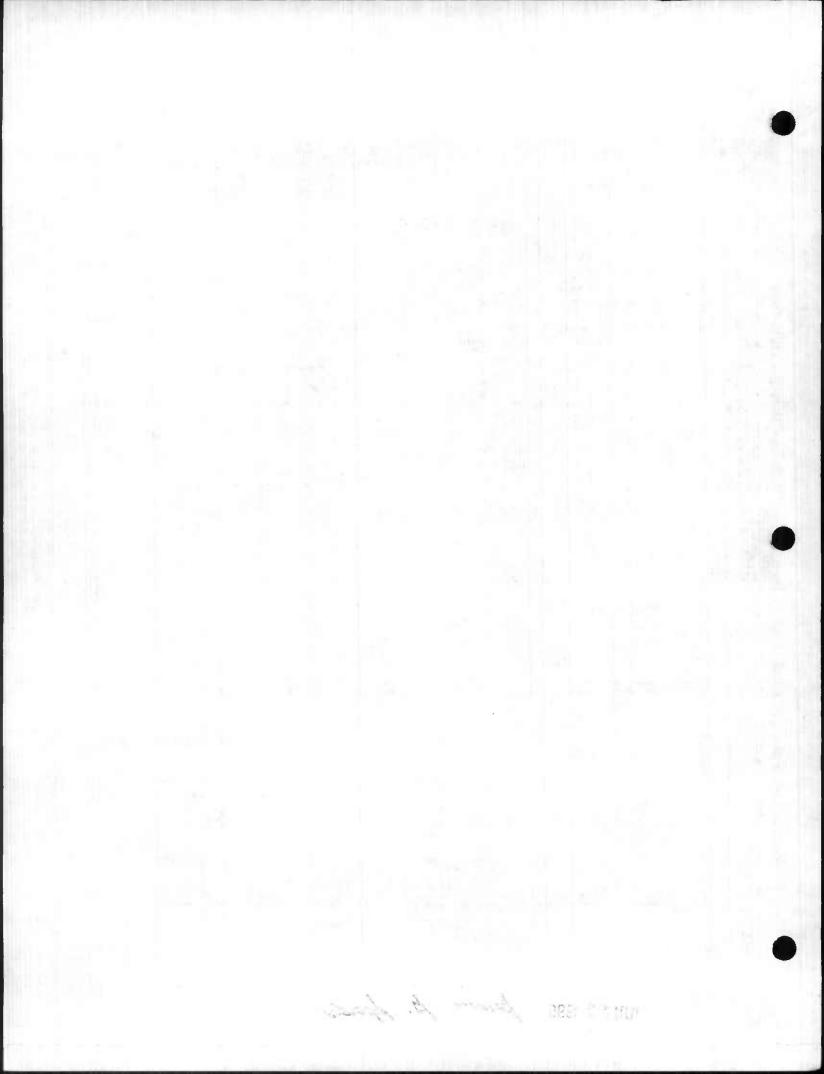
32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

County A man at a secret con.

					State of M	aryland /		irtment of F tificate of	Death	Mental Hy	giene Reg. No.	9	21829
			Decedent's Nem	e (First, Middle, Las	st)					2. Date of De		Vana	3. Time of Death
e.	Physiciar /Medica	_	VICTOR .	J MORELAN	D					June 2	7, 1999	Year	9:45 a.m.
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4			14414 U	hl Highwa	v SE				Cumberla	nd	Alle	oanv	
	Funeral	5. 5	Social Security N	umber 6. S	8x 7. A	ga (In yrs. last i	birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bi			place (Stata or Foreign
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	those .		a. Stata	10b. County		10c. City, To	own or Lo	cation				1	IOd. Inside City Limits
	M Par	010	MD	Allega	ny	Cumbe	erlan	d					1 ☐ Yes 2 No
	sth with the Maryla 23s or 28s-f shor sat be notified at	100	e. Street and Nur	nber				10f. Zip Code			10g. Citizen of 1	What Cour	ntry?
	D will		14414 UI	hl Highwa	y, SE			21502			USA		
	8 5 5	11.	Maritel Stetus		12. Was Decedent Armed Forcas		13. V	Ves Decedent of I	Hispanic Origin? (S	Specify Yes or No			can Indian,
0	atter or mine		1 Never Merri	ed 2 Merried	1 X Yas 2□	No		☐ Yes 2 No		to rucan, atc.)		ck, Whita,	etc.
02	E F.	ο a	3 D Widowed	4 Divorced	If Yes, Give Year or Dates:	WW II	1	LIYes 2MNo	Specify:		Specify	Whit	ie .
21215-0020	72 hours after natural, or to dical Examina	Completed	/0	15. Decedent's Ed	ucation	16	Sa. Deced	ent's Usual Occup	pation	elain e	16b. Kind of B	usiness/In	dustry
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P	2165 .		Father's Name	(First, Middla, Last)					18. Mother's Na	me (First, Middle	, Maiden Suman	na)	
Maryland	Mental Mental arked o	0	Frank :	B. Morela	nd, Sr.				Regina	(Griffin	1)		
any	4566		a. Informant's Na	me/Relationship (7	Type, Print)	11	9b. Mailin	g Address (Street	t and Number or R	ural Routa Numb	er, City or Town,	State, Zip	Code)
Σ	and 2 neath a n 27 is	G1	oria F.	Moreland	-wife	14	4414	Uhl High	nway SE;	Cumber1	and, MD	215	02
ē,	- 1 1 5		a. Mathod of Disp			20b. Place	of Dispos	sition (Nama of natory or other pla	1	Data	20c. Location		
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	dead de att	Par	t II. Other algnifi	cant conditions of	ontributing to death b	out not rasulting	in the un	derlying causa gi	ven in Part I.	23b. Did	tobacco usa co	ntribute t	o the cause of death?
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0	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Madical Certification:	5											
	ne Hospital ne Funeral pletely filled	29	a. Certifier (Check only	Cortifying Phy	valcian: To the best	of my knowled	ge, death	occurred at the ti	ma, date and place	e, and due to the	cause(s) and m	anner as s	tated.
	the F		one)		and manner st			oongation, with t		oned at bio time.	outo ano piaco,	4110 000 0	7 010 0200(0)
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		30.	Nama and addre	ess of person who o	complated causa of o	death (Item 23s	a) (Type, f		, 0		oune &		3
	me				625 Kent				lumberl on	d MD	21502		
	State	0.4	Date filed (Mont	h, Day Year)	32-Registr	rar's Signatura	L	1	GIIDELIAII	LID Z	1302		
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	4	_]	1. Decedent's Name (First, Middle, Last,)						2. Dete of Dee	th	Vene	3. Time of Deeth
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	Examir		4e. Fecility Neme (If not institution, giva	street end numbe	er)			4b. City, Tov	wn, or Lo	cation of Death	4c. County		
			34 West College Avenu				1	Frostbu	-		Alleg	any	
	Funeral Director		220-10-1072	TIC MAR	Age (In yrs. last b BO	virthday) Yrs.	If Under 1 Yaar Months Days		Min.	8. Data of Birth (Month, Day 16-Nov-1		Cou	plece (Stete or Foreign ntry) Virginia
	and #		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation						10d. Inside City Limits
	Mary Fish	io	Maryland Allegany		Frostbur	a							1 Yes 2 No
	r 28e	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen of	What Cou	ntry?
	h wit		34 West Coll	lege Aven	iue		21532-				U.S.A.		
	eep	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U,S.	13. V	Vas Decedent of I Yes, specify Cub	Hispanic Orig	gin? (Spe	ecify Yes or No-		e - Ameri ck, White,	can Indien,
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15	C ' S	Completed	15. Decedent's Edu (Specify only highest gred	e completed)	16	e. Deced (Give life. L	lent's Usuel Occu kind of work done OO NOT use ratire	pation during most d)	of worki	ng	16b. Kind of B	usiness/in	dustry
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pu	be filed the filed of other if	Bec	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle, I	Ma <i>iden Sum</i> en	ne)	
ylaı	should be and Mentel marked o	To	Joseph A. McGreevy					Eva La	Rue				
Maryland 21215-0020	O1 00 07 m	Ì	19a. Informant's Name/Relationship (Ty		19	9b. Mailin	g Address (Stree	t end Numbe					
	2 # Z		Joseph N. McGreev Sc	on			Creek Road	d	Front	Royal	Virginia		2630-
Baltimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	lemovai from Ste				emetery	29		20c. Location		
Balt	pemit. Pege Department of Important: if any injury or once.		21. Signature of Funeral Servica Licent	Duris	1		Name end Addre			rost Ave.,	Frostburg	, MD	21532
	Physician /Medical Examiner	ner	Immediate Ceuse (Final disease or condition rasulting In death)	ST	Due to (or as	S	uence of):	CA	u	2~~		7	Onset end Death
ox 68760,	deeth certificate be executed e ettending physician and of for use es the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last))	Due to (or as a								
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P.O.	thet the ed by th deteche		retti. Otter significant conditions con	minuting to death	i but not resulting	in the ur	idenying cease gi	ven in rait i.		1 □ Y	N		bably 4 Unknown
Records,	been should	Completed by								24a. Was a		an Co	fere autopsy findings yeilable prior to emplation of cause death?
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ita	iclan: The certificate rector, pag	Be C	25. Was case referred to medical					26. Place	of Death	(Check only or	ne)		
of Vital	S S D	To	axaminar? 1 ☐ Yes No	lospital: 1 ☐ Inpa	atient 2 ER/C	Outpatien	t 3 DOA	her: 4 🗆 Nu	rsing Ho	me Reside	ence 6 Oth	nar (Speci	fy)
n o	ding Ph h. After th funeral		27. Menner of Death Natural 5 Panding	28a. Dete of II	njury 28b Da <i>y Year)</i>	. Time of Injury	28c. Inju			28d. Describe h	ow injury occur	red	
Division	I or Attending efter death. Director: Afte d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		Injury - At home, etc. (Specify)	ferm, stre	M 1 C]Yes 2 □ 1		281. Location (S City or Town		ber or Rur	al Route Number,
	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral	edical Ce	29a. Certifier 1 Cartifying Physic (Check only one)	alcian: To the be- her: On the basis and manger	of examination e	ge, death and/or inv	occurred at the ti	me, dete and opinion, deel	d place, o	and due to the c ed at the time, d	ause(s) and m late and place,	anner as s	stated. o the cause(s)
		Me	29b. Signature and title of certifier		\		29c. Licen	se number	2	2	Date signe	8 (Moving	Say, Year)
	/3		30. Name and address of person who co	noteted cause of Memor	f death (Item 23a) (Type, I	Print) mberland,	ot L Maryla	nd, 21	502	10	100)
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 8 1999	-	strar's Sign		and						

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Maryland Allegany

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Joseph A. Mc Greevy

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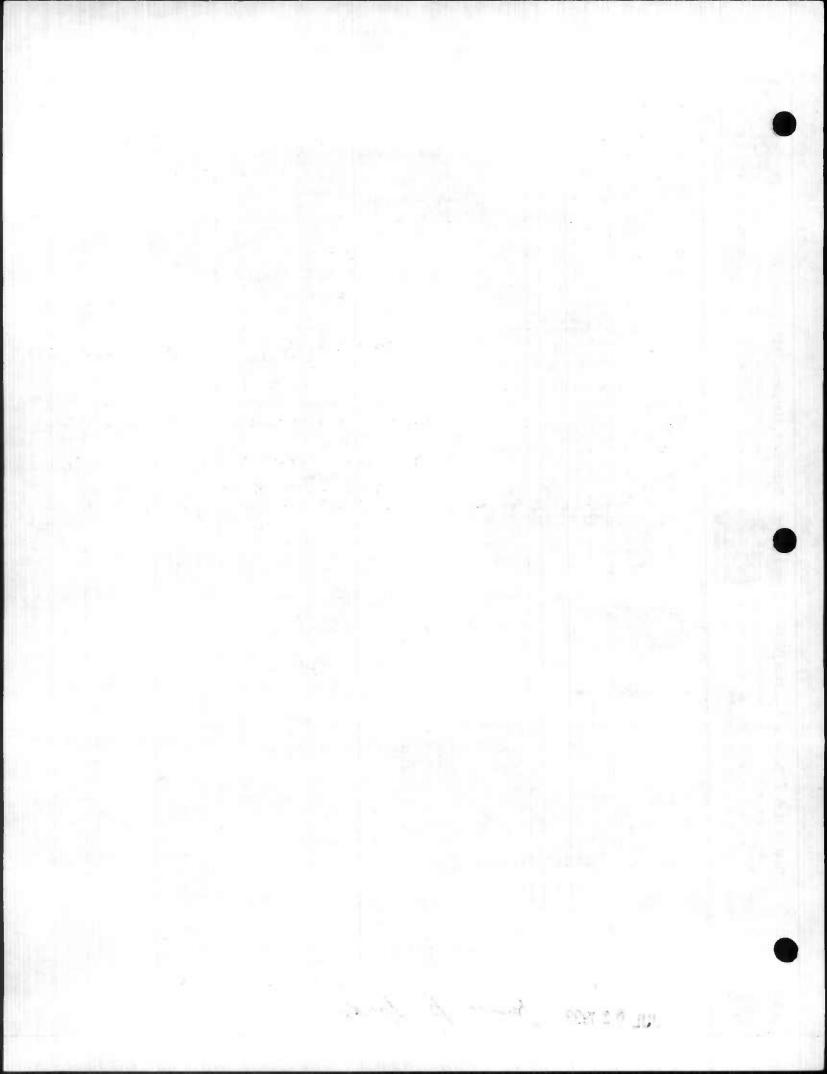
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Gry W. Hisus, M.D. 300 Memorial Avenue, Combedanii Malyland, 21 MF

State of Maryland / Department of Health and Mental Hygiene

			Ce	rtificate d	of Death		Reg	. No.	- 6.	1031
	1. Decedent's Name (First, Middle, La	st)					ete of Death		V	3. Time of Death
Physician /Medical	DIANE K. MAMIC	Н					Aonth JUNE	30 1	Year 999	3:20PM
Examiner	4a Facility Name (If not institution, giv	e street and number)			4b, City, Tov	vn, or Locatio		4c. County		3.20111
	SACRED HEART H	OSPITAL			CUMBE	RLAND		ALLE	EGAN	Y
Funeral Director	214-82-2940	□M 20 F	rs. last birthday) Yrs.	Months Da		Min. (ate of Birth Wonth, Day, Y			lace (State or Foreig try) YLAND
P .	Usual Residence of Decedent 10s. State 10b. County	100	City, Town or Lo	nontino						0d. Inside City Limits
ahou ahou									- '	1 Yes 2 No
or 28e-fall	MARYLAND GARR	EII	FROSTB	1				6 11		
th with the Maryler 23a or 28a-f ahow set be notified at rai Director	10e. Street and Number 294 OLD FROSTB	URG ROAD			532	. 1		USA		
72 hours efter death with the Maryland netural; or Itama 23s or 28s-f ahow stall Esseries must be notified at sted by Funeral Director		12. Was Decedent Ever in Armed Forces? 1 Tyes 22 No If Yes, Give Year or Dates:		Wes Decedent If Yes, specify 0 1 ☐ Yes 2 ☐	of Hispanic Orig Cuban, Mexican No Specify:	in? (Specify ' , Puerto Ricar	Yes or No- n, etc.)		k, White,	an Indian, etc.
ed within 72 hours yplene. Ar then "netural", A, the Medical Completed by	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Oc	cupation one during most	of working	16	b. Kind of Bu	siness/in	dustry
within 7 then "r	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	tired)					
Hygiena. Hygiena. ther than mt, ma	12	2	6031		ERVICE	LTATI				NICATION
EISE A	17. Father's Name (First, Middle, Last)						st, Middle, Ma		(0)	
nd Mentel narked o umatic ave	HERBERT CESSNA	, JR.			DEI	ORES	STOTI			
2 sho	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (St	reet and Numbe	r or Aural Ao	uta Number, C	City or Town,	State, Zip	Code)
P 52 5	VICKIE MAZER/S	ISTER	294	OLD FR	OSTBUE	RG RD,	FROS	TBURG	G, MD	21532
of Heal	20a. Method of Disposition		. Place of Dispo	osition (Name o	f place)	De		c. Location -	City or To	wn, Stete
permit. Pages Department of i Important: If hi any injury or o	1 Donation 5 Other (Specif	Removal from State					LY	CDANT	POVI	LLE, MD
death certificets be executed a strending physicien and of or use as the burlal-transit sician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Con Due to	(or as a consection of the con	quence of):	faiter logst	n				30 days 30 days 30 days
dead dead	Part II. Other significant conditions of	ontributing to death but not n	esulting in the u	inderlying cause	given in Part I.		23b. Did toba	acco use cor	ntribute to	the cause of deat
igned by the attendit be deteched for use by Physician/							1 A Yes	2 □ No	3 Pro	bably 4 Unknow
s been a 2 should pleted							24a. Was en performe		ev	ere eutopsy findings eilable prior to mpletion of cause death?
Com page							1 🗆 Yes	2 000	1 [Yes 2 No
certificata rector, page 20	25. Was case referred to medical examiner?				26. Place	of Death (Ch	eck only one)			
8 00 5	1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Other: 4 Nu	rsing Home	5 Rasiden	ce 6 Oth	er (Specit	(y)
Attanding Phi is deeth. ector: After thi by the funeral	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		Injury at Work? 1 ☐ Yes 2 ☐ f		Describe how	injury occum	red	
	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, st cify)	reet, factory, off	ice		ocation (Stre City or Town,		er or Rur	al Route Number,
vithin 24 hours after the Funeral Direction of completely filled in Medical Cert	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	yelclan: To the best of my k niner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	h occurred at the exestigation, in r	e time, date and ny opinion, deat	d place, end d th occurred at	ua to the cau the time, date	se(s) and me e and place, a	nner es s and dua t	teled. o the cause(s)
To the Ho within 24 Pu completely	29b. Signature and title of certifier			29c. Lic	ense number		290	. Dete signed	d (Month,	Day, Year)
4	1	(Bran	mo		D125.	32	J	4/4/	119	7
10	30 Alema and address of account	nompleted source of the state of	am 22al (T					//	- [[
ms	30 Name and address of person who	W D Q C	2 .		-1	MA				
	George Breza.	M.D. 712 Set	on Drug	e lumb	serland	1-00	2151	المان		
State	31. Data filed (Month, Day, Year)	32. Registrar's Sig		Carlo		1 00	4121			

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-				State of Ma	aryland /		artment rtificate			ind M		giene Reg. No.	9	9 2	118	32
	Dharala		Decedent's Name (First, Middle, Last)								2. Date of De Month	ath Day		Year	3. Tim	e of Death
	Physic /Medi		Irene Catherine Mine	lla							June	29		999	02:10	PM
	Exami		4a. Fecility Neme (If not Institution, give s					1.4	lb. City, Tov	wn, or Lo	ocation of Death	100		of Death		
	4		Saint Vincent dePaul N				If Under 1		rostbur If Under 2	-	T	-	llego			
	Funeral Director		5. Sociel Security Number 6. Sex 091-36-1108 Usual Residence of Decedent	7. Ag	e (In yrs. lest	Yrs.		Days	Hours	Min.	8. Date of Bir (Month, De 04-Dec-		1	9. Birthpl Count New Y	try)	ate or Foreign
	yland		10a. Stata 10b. County		10c. City, To	own or Lo	cation							10	Od. Insid	e City Limits
	Mar and sel	ctor	New York Monroe		Roches	ter									1页	Yes 2□No
	th with the	al Director	10e. Street end Number 85 Hartesdal	e Road			10f. Zip 0					10g. Chiz		/het Coun	fry?	
020	ges 1 and 2 should be filed within 72 hours after death with the Manyland it of Heelih end Mentel thyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 Yes If Yes, Give Year or Dates:		it	Vas Decede f Yes, specif I □ Yes 2	ly Cube	Ispanic Origin, Mexican, Specify:	gin? (Spo , Puerto	ecity Yes or No Rican, etc.)			a - America k, White, d		n,
5	72 ho	ed	15. Decedent's Educ (Specify only highest grade	cation	10	6a. Deced	lent's Usuel kind of work	Occup	ation	of work	ina	16b. Kir	d of Bu	siness/Ind	lustry	
21215-0020	d within giene. er then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	bank	OO NOT use	retired)	OI WOIN	ing	comp	any t	bank		
Maryland	of file	Be (17. Fether's Neme (First, Middle, Last)								e (First, Middle,	Meiden :	Sumam	e)		
yla	should be and Mentel marked or umatic eve	2	Edward Scheld, Sr.						Johani	na W	eber					
Mar	12 sh end fa m		19e. Informant's Name/Relationship (Ty)		1	9b. Maitin	g Address (Street			A Courte Number					
	1 and Heelth In 27 ther tr		Joan Minella Do 20e. Method of Disposition	aughter		Box 57	77 sition (Neme	e of		MOU	nt Savag		-	City or To	1545-	
altimore,	. Peges iment of l tant: If its jury or o		1 Burial 2 □ Cremation 3 □ Ri 4 □ Donation 5 □ Other (Specify)	emoval from State	came	etery, cren	re Ceme	ner plac	9)	0				New		
Ba	permit. Peg Department Important: i any injury o		21. Signeture of Funeral Servica Licanse	Du	ut	-	Name and		-		rost Ave.	, Frostl	ourg.	, MD 2	21532	2
	Physician		23e Part I offer the disease, or compile the control of the contro	cetions thet caused e cause on each lin	the death. D	o not ente	er the mode	of dyin	g, such as o	cardiac	or respiratory e	rrest,				mate Between and Deeth
	/Medical Examiner		Immediate Ceuse (Final disease or condition	ESOPH	AGE	4-1	CXR	C-I	NOL	14					2 4	10
	Examiner	Ļ	resulting to death) a		Due to (or as					.,						1-31
	bed sit	nine	_ b											1		
6	be axecuted sician and burial-transit	Examiner	Sequentialty list conditions, if any, leading to immediate		Due to (or es	e conseq	uence of):									
09/89	th of	dicai	cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last		Due to (or as	a consequ	uenca of):									
gox	eath certific attending p	Physician/Me	d.			_								1		
5	the attenthed for n	/sic	Part II. Other significant conditions cont	tributing to death bu	ut not resulting	g in the ur	nderlying cau	use giv	en in Part I.		23b. Dld	tobacco	iee con	tribute to	the cau	se of death?
7.	v requires that the de been signed by the should be deteched	by Phy									10	Yes 2	XNo	3 □ Prob	ably	4 □ Unknown
ecords,	2 8 8	Completed									24a. Was perfo	an autop med?	sy	ava	itable pr	esy findings for to of cause
r	age age	E O									10	Yes 25	No	1 🗆	Yes	210 No
N I I	ysician: T is certifical director, p	Be	25. Was case referred to medical examiner?							of Deett	Check only o	ne)				
0	Physic this c	ဥ	1 ☐ Yes 205 No	ospital: 1 Inpatie		Outpatien			4 Jaknur		me 5 Resid)	
noi	ling I After fune	ation	27. Manner of Deeth 1 Netural 5 Pending 2 Accident investigation	28e. Dete of Injur (Month, Day	Year) 28t	o. Time of Injury	M 280	c. Injun Worl	/at ⟨? Yes 2 □ N		28d. Describe	now injury	occurr	ed		
-	al or Attend s after death il Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ HomIcide determined	28e. Place of Injubuilding, etc.	ury - At home, c. (Specify)	farm, stre	et, factory,	offica			28f. Location (: City or Tox		f Numbe	er or Rurai	Route I	Vumber,
	To the Mospital or within 24 hours after To the Funeral Dir complataly filled in	edical (29a. Certifier (Check only one) Certifying Physical Examination	clan: To the best of er: On the basis of end manner sta	examinetion :	ige, death and/or inv	occurred at estigation, in	the tim	ne, dete and pinlon, deat	place, a	and due to the ed at the time,	cause(s) date and	and ma placa, e	nner as sta end due to	ated. the cau	se(s)
	within 2 To the compla	M	29b. Signeture end title of cartifier	0 1		^	29c.	License	number			29d. Dete	signed	(Month, L		
	6		Malustian	4. Sa	nen	4			486			JUL	-		19	99
	nus		30. Neme end addrass of person who cor Robustiano J. Barrera,	M.D., Mem	eath (Item 23a Orial Hos	spital	Medico	al Bu	llding,	Cum	berland,	Mary	and	21502		

Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No.

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Physician	l
/Medical	L
Examiner	

2. Data of Death 3. Tima of Death 1. Decedant's Nama (First, Middle, Last) Month 10:00PM June 28, 1999 HILLEN JEROME MORGAN, SR. 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Civista Medical Center La Plata Charles if Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
APRIL 30, 1908 5. Social Sacurity Number 7. Ana (In vrs. last birthday) If Under 1 Yaar Birthplaca (State or Foreign Country) **Funeral** Months Days 1 M 2 F 91 Yrs. 214-30-2234 MARYLAND Director Usual Residance of Dacedant the Marylend 10d. Insida City Limits 10c. City, Town or Location 10a Stata 10b. County "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 Yas 2 No Directo MARYLAND CHARLES LA PLATA 10f. Zip Coda 10g. Citizan of What Country? 10e. Street end Number Pages 1 and 2 should be filed within 72 hours efter death with teen of Health and Mental Hygiene.
mit if them 27 is marked other than "natural", or Hema 23a or 2 marked other than "natural", or when traumate avent, the Medical Exeminal mail to or other traumate avent, the Medical Exeminal mail to a 6715 VALLEY ROAD 20646 U.S.A. Funerai 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarlo Rican, atc.) 12. Was Dacedant Evar in U.S. 14. Raca - Amarlcan Indian, 11. Marital Status Black, Whita, atc. Yas 27 No 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: WHITE g 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa, DO NOT usa ratired) 16b. Kind of Businaas/Induatry 15. Decedant's Education (Specify only highast grada complated) Elamentary/Secondary (0-12) Coilaga (1-4or 5+) FARMER FARMING 18. Mother's Name (First, Middle, Maldan Surnama) 17. Fathar's Nama (First, Middla, Last) LILLIAN CATHLEEN EICHELBERGER ROBERT E. LEE MORGAN 19b. Melling Address (Street and Numbar or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lepartment of Hear Important: if Item 27 any Injury or other PDES. LAURA REES MORGAN-SPOUSE SAME AS #10 20b. Place of Disposition (Neme of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Steta 1 Burial 2 Cramation 3 Ramoval from Stata ST. IGNATIUS CH. CEMETERY 7-2-99 PORT TOBACCO, MD. 4 Donation 5 Othar (Specify) 21. Signatura of Funarai Sarvice Licansee 22. Nama and Addrass of Facility RAYMOND FUNERAL SERVICE, P.A.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert fellure. List only one cause on each line. Approximata Intarvai Batween Onsat and Death **Physician** /Medical Immediate Cause (Finel 10 Days Pneumonia disaasa or condition rasulting in daath) Examine Dua to (or as a consequence of): Examiner physician and the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immadiate causa. Entar Undarlying Causa (Diseasa or Injury that initieted avents rasulting in daath) Last Due to (or es e consequence of): Box 68760 Physiclan/Medical Dua to (or as a consequence of) Se attending p the bec 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be detech 1 Yes 2 No 3 Probably 4 Unknown Methicillin Resistant Staphylococcus Infection Division of Vital Records. by 24b. Wara autopsy findings available prior to completion of cause of death? 24e. Was an autopsy Completed Urosepsis, Atrial Fibrillation, Alzheimer's Disease performed? s certificate has l 2 No 1 Yas 1 ☐ Yas 2 ☐ No Diabetes Mellitus, Non Q Wave Myocardial Infarction or Attanding Physician: director, 25. Was casa rafarred to medical axeminar? Be 26. Placa of Daath (Chack only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 inpatiant Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Menylar of Death 28a. Data of Injury (Month, Dey Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury et Work? After 1 Naturel 5 Panding death. 1 ☐ Yas 2 ☐ No investigetion after death Director: A 2 Accident 3 ☐ Suicida 6 Could not be determined 28f. Location (Streat and Numbar or Rural Routa Number, City or Town, Stata) 28e. Pieca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Dis completely filled In Hospital 15 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, date and place, and dua to tha causa(s) and mannar as stated.
2 Medical Examiner: On tha basis of axamination end/or invastigetion, in my opinion, deeth occurred at tha tima, date and place, and due to the cause(a) and mannar stated. Medical 29a. Cartifiar To the 29d. Data signad (Month, Day, Year) 29c. Licansa number 29b. Signatura and titla of carifian D-37174

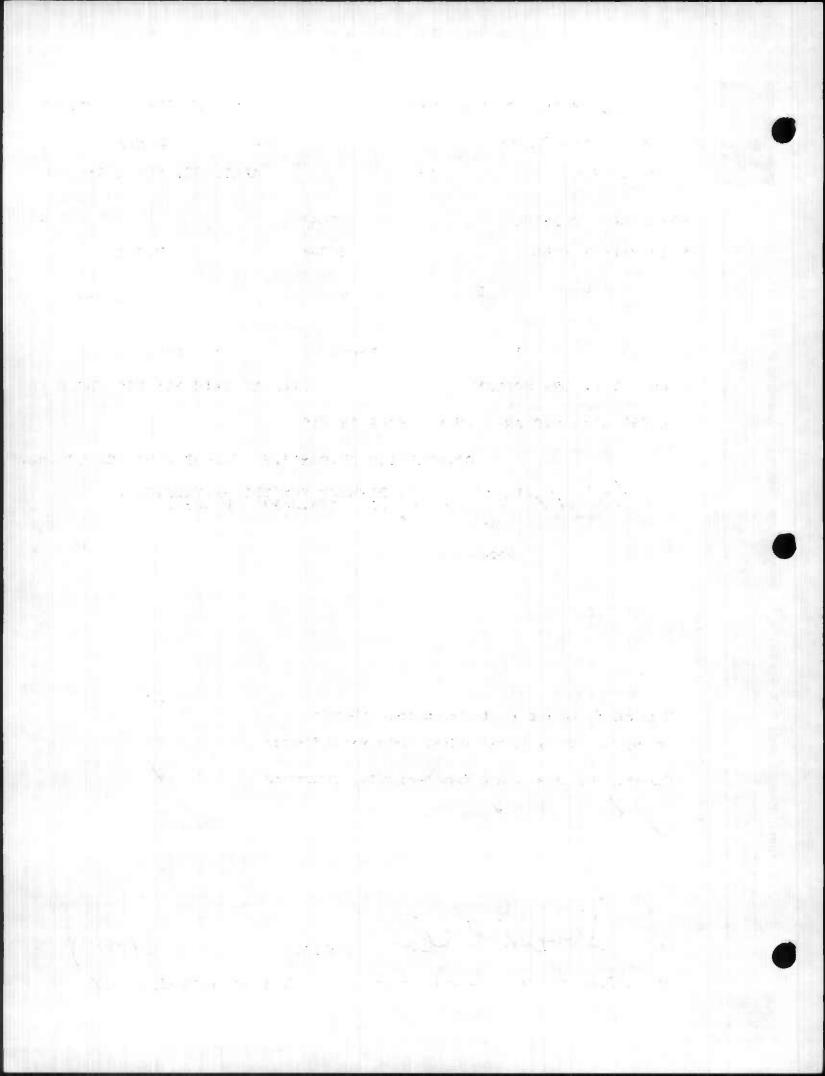
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Song C. Chon, MD

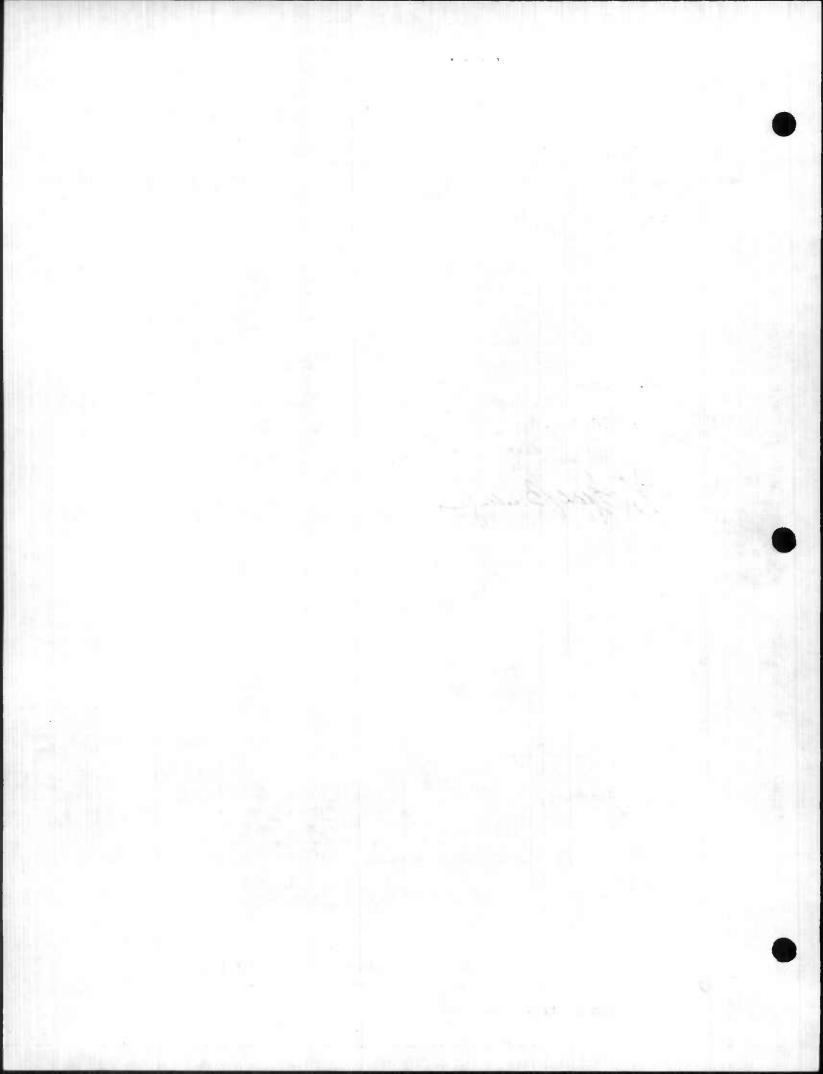
Cenna Medical Center-7C Post Office Rd., Waldorf, MD 20602 32. Registrar's Signatura

30. Nema and address of person wito complated causa of daath (Item 23e) (Type, Print)

Locks



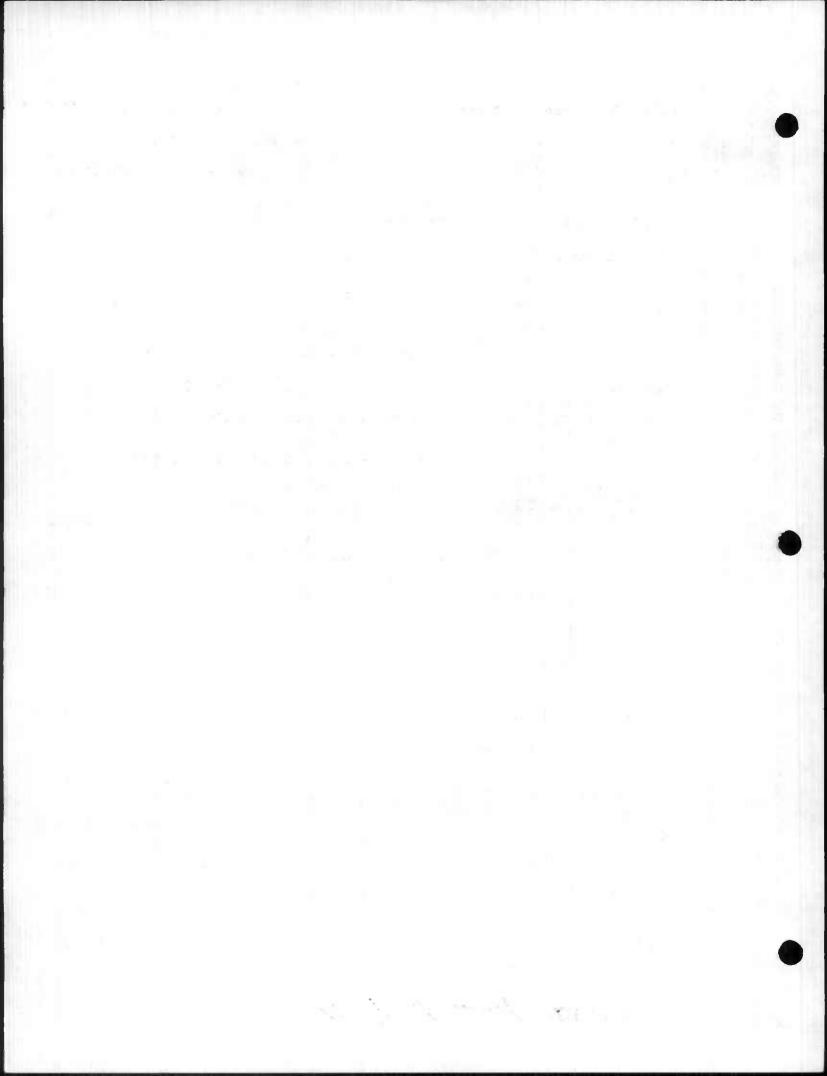
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Lest) 3. Time of Death Day Month Year **Physician** JOHN LAWRENCE MICHAEL 6 29 99 2:30 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Berlin Worcester 7 Birch Place If Under 24 Hrs If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours Min 1**X** M 2□ F 216-18-9625 Yrs 74 Director 8/30/24 MD Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits ehow ras 23a or 28a-f ehov Worcester MD Berlin 1 Yes 2 No **Funeral Director** 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Birch Place 21811 USA 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? or items 11 Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after near of Health and Mental Hygiene. 1 Yes 2 No 1 Never Married 2 Married 21215-0020 WWII 1 Yes 2 No Specify: Specify: white py 3 Widowed 4 Divorced Year or Dates: Be Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Steel Co. Crane Operator 7 to marked other traumatic event, Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Michael Georgeanna (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Michael/ Wife 7 Birch Place Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removel from State = 8 Cape Henlopen Crematory 6/30/99 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) vice Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St. Berlin, MD ease, or complications that cause if the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, ire. List only one cause on eagle ine. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) INDIMA Examiner Examiner The law requires that the death certificate be executed the burial-tran Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): pug Box 68760 Physician/Medical Due to (or as a consequence of): ate has been signed by the attendin page 2 should be detached for use P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably L Unknown 1 Yea 2 No Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an eutopsy performed? 1 Yes 2 No 1 TYPS 2 DAG certificate Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpetient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 DNatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 5 Pending investigation To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and plece, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 5 ne and address of person who completed cause of death (Item 23a) (Type, Print) JOSOPA me shea 30. Nan BERLIN Ste 1051 RACK 32. Registrar's Signeture 31. Date filed (Month JUN 3 0 1999 State Registrar



State of Maryland / Department of Health and Mental Hygiene

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						Cer	tificate o	f Death			Reg. No.		0 8	- 13	
		Ш	1. Decedent's Neme (First, Middle,	Last)						2. Dete of De	eeth		V	3. Time	e of Deeth
	Physici /Medi		Estella M	lae Por	ter					Month 0.6	2.6		Year 999	7	:00pm
	Examir		4e. Facility Neme (If not institution,					4b. City, To	wn, or L	ocation of Deat		County o	and the same of th		
			EGLE NURSING H	OME				LONA	CONI	NG	A	LLEGA	ANY		
	Funeral Director		5. Sociel Security Number 214 07 2459 Usuel Residence of Decedent	6. Sex 7. Ag 1 ☐ M 2 🛣 F	ge (In yrs. lest i 82	birthday) Yrs.	If Under 1 Year Months Dey		24 Hrs. Min.	8. Dete of Bir (Month, De OCT 6	1916	ı	9. Birthpl Count MARY	ace (Sta (IV) LAND	te or Foreign
	puel a		10e. Stete 10b. County		10c. City, To	wn or Lo	cation						10	Od. Inside	e City Limits
	the Mary 28a-f sh	Director	MARYLAND ALLEGA	NY	FRO	STBU	RG 10f. Zip Code				10- Ciri	izan of Wi		1 🗆 Y	es Ž□ No
	ath with	rai Di	1911 GREEN ROW				2153					.S.	net Couri	uyr	
21215-0020	be filed within 72 hours after death with the Maryland tall Hygiere. Id other than "natural", or items 23a or 28a-f show event, the Medical Exertine must be notified at	by Funeral	11. Maritel Stetus 1 □ Never Married 2 □ Merrie 3 □ Widowed 4 □ Divorced	12. Wes Decedent Armed Forces? 1 Tyes 2 1 If Yes, Give Yeer or Detes:		If	Ves Decedent of Yes, specify Cu	iben, Mexice	n, Puerto	pecify Yes or No Rican, etc.)	D-	14. Rece Bleck Specify:	, White, e		
5-0	72 ho	Completed	15. Decedent's (Specify only highest	Education grade completed)	16	a. Deced	ent's Usuel Occ kind of work don	upation e during mos	t of work	kina	16b. Ki	ind of Bus	iness/ind	lustry	
121	within ene.	Jdm	Elementery/Secondary (0-12)	Collage (1-4or		life. L	OO NOT use retii	red)							
7	Hygier ther the		8			HOUS	EKEEPING	_				PITA			
Maryland	should be fi and Mental It marked out	To Be	17. Father's Nema (First, Middla, L ARCHIE HOTT	#Sf)						e (First, Middle STEVEN		Sumame)		
	d d d		19a. Informent's Name/Reletionshi THOMAS E. PORTE				g Addrass <i>(Stre</i> AKWATER				_			Code)	
Baltimore,	permit. Pages 1 en Department of Heal Important: If Item 2 any injury or other once.		20e. Method of Disposition 1 ☐ Surial 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Special Control of the Control	B ☐ Removel from State	ceme	tery, crem	sition (Name of netory or other p		K 6/	Dete 29/99		TBUR	1		
Balti	Departm Departm Importal any inju	, T	21. Signeture of Funerel Service Li		11001	22.	Name end Add	ress of Fecili	ty						
_		L	Cruca	sour .	_	60	W. MATI	N ST.	FRO	STBURG.	MD	2153	2		
			23e. PertT. Enter the disease, or c shock, or heart feilura. List o	omplications that caused nly one causa on each li	d the daath. De ne.	o not ente	er the mode of d	ying, such es	cerdlec	or respiratory e	rrest,		1	Approximation Interval I	nete Between nd Deeth
	Physician /Medical		Immedieta Causa (Final	0 -	0 1	Α		^ _							
	Examiner		diseese or condition resulting in death)	. Ucule	Careb	ral	Vascu	lar C	Rece	tuske				20	mun.
		Jer		. acute Benero	Due to (or es	a conseq	uance of):	0	_				i ,	0 4	10006
	outed od ansit	Examiner	Sequentially list conditions	b. Cenera	Dua to (or as			SOLO S	15					9	racs
Ó	an ar	EX	Sequentially list conditions, if eny, leading to immediate causa. Enter Underlying Cause (Disease or Injury												
68760,	ate be hysici	edical	thet initieted evants resulting in deeth) Last	C	Dua to (or as	consequ	ience of):								
×	eath certificate be executed attending physician and for use as the bunal-transit	Σ	Tooling III doolin, 2ast	d											
. Bo	ires that the death co signed by the attend d be detached for us	Physician/	Pert II. Other significant condition	s contributing to death b	ut not resulting	In the un	darivino causa o	oivan In Part	1	23b. Did	tobacco	use cont	ribute to	the caus	se of death?
<u>о</u> .	t the by th tache	hys	D-1+ 10	00 t	at the trouble and		aunying souso (great in the original			Yes 2		3 Prob		Unknown
	gned gned	by F	Diabeles VI	Clulus											74
Records,	requ been shoul	Completed	Dementia	- alyher	mer's	16	the			24a. Was perio	en eutop ormed?	osy	eve	re eutopa elleble pri mpletion daeth?	sy findings for to of cause
	The law ite has bage 2	Com		•						10	Yes 2	No No	1 🗆	Yes 2	2□ No
IIa	ucian: The certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place	of Deat	th (Check only o	one)	-			
2	Physic this ce rai dire	To	1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 ER/0	Dutpetient	3□ DOA C	ther: 400Ni	ursing Ho	oma 5 🗆 Rasi	dance (6 □Other	(Specify	1)	
Division of Vital	nding Pi ath. r: After the se funera		27. Mannar of Deeth 1 Netural 5 Panding 2 Accidant investiga	28a. Deta of Inju (Month, Da	y Year) 28b	Tima of Injury	28c. Inj W M 1	uryet ork? □Yes 2□	No	28d. Describe	how Injur	у оссипе	d		
Divis	after de Directo d in by th	Certification:	3 ☐ Sulcide 6 ☐ Could no 4 ☐ Homlolda datermin	t be ed 28e. Plece of Inj building, at	ury - At homa, c. (Specify)	farm, stre	et, factory, office	8		28f. Location (City or To			or Rurel	Route N	lumber,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edicai C	29a. Cartifier (Check only one) 1 Cartifying 2 Medical Ex	Physician: To the best of taminar: On the basis of end menner sta	exemination e	ga, death and/or inv	occurred et the estigetion, in my	tima, date en opinion, das	d plece,	end due to tha red at the time,	cause(s) date and	end meni i place, an	nar es ste nd due to	etad. the ceus	e(s)
	outh ompl	Me	29b. Signature and title of certifier			-	29c. Lice	nse number			29d. Det	te signed	(Month, E	Day, Year	r)
	8		1 Hughi	Je Hw	M		Do	20	04	- <	1	re 2		1999	7
	0		30. Name end eddrass of person w	no completed chuse of d	aath (Item 23e) (Type F	Print)				1		- 1		
	mes		L.R. M.LES, V 31. Data filed (Month, Day, Year)	R, M.D.	57 1		50N ST	, Lo	NAC	201110	5 1	ND	2	153	19
	Sta Registr		JUN 2 9 19		ar's Signetura	Ø.	page start								



Preston

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

icallii and i	Mental Hygie	ne	2 836
Death	Reg.	No.	
	2. Date of Death Month Jun 27	Dey 1999	3. Time of Death 09:45am
4b. City, Town, or L	ocation of Death	4c. County of Deatl	h
Cumberl	and	Al.	legany
If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Ye	9. Birtl Co	hplece (Stete or Foreign MD
			10d. Inside City Limits
d			1 XYes 2 □ No
	10g.	Citizen of What Co	untry?
21502		USA	
lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	e, etc.
Specify.		Specify: wh.	ite
pation during most of world)	king	o. Kind of Business/	Industry

Jun 28, 1999

the Maryland 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examinar must be notified at deeth e filed within 72 hours effer of thygiene. "natural", or

Physician

/Medical

Examiner

Director

Funeral

Director

Funeral 1 Yes 2 No Specify: Baitlmore, Maryland 21215-0020 by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) seamstress permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important: if flem 27 is marked other any lojury or other traumatic event, and 17. Father's Name (First, Middle, Last) Paul R. Goldsworthy Carol E 19a. Informant's Name/Relationship (Type, Print)
Paul A. Preston husband 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mary's Cemetery 21. Signature of Funeral Service Licensee Cumberland, Maryland **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Arteriosclerotic Heart Disease Examiner Due to (or as a consequence of): Examine Diabetes Mellitus The iew requires that the death certificate be executed physician end a the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Chronic Renal Failure Physician/Medical Due to (or es a consequence of) algned by the a d be detached f Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P been si Completed page 2 s certificate or Attending Physicien: director, 25. Was case referred to medical examiner? 8 examiner: 2 1 Inpatient 2 ER/Outpatient 3 DOA this s funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? After Natural 5 Pending investigation deeth. 1 Yes 2 No 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide tU Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Ideal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2 To the 29c. License number 29d. Dete signed (Month, Dey, Year) 6 D09157 wMo completed cause of death (Item 23a) (Type, Print)
I.D. 124 W. 3rd Street Cumberland MD 21502 Paul Snow M.D.

610 Montgomery Avenue Cumberland 8. Date of Birth Feb 26, 1954 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Days Months Hours 1 M 2 F 217-66-9486 45 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What 21502 USA 610 Montgomery Avenue 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☐ ¥o
If Yes, Give
Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - A Black, W 1 Never Married 2 Married Specify: W 16b. Kind of Busine Kaufman' 18. Mother's Name (First, Middle, Maiden Sumame) (Moon) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 610 Montgomery Avenu; Cumberland, MD 21502 20c. Location - City or Town, Stete 6/30/ Cumberland, MD 235carpelii Funeral Home P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth 3 years lifetime 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to 24a. Wes an autopsy performed? completion of cause of death? 2 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 281. Location (Street and Number or Rural Route Number, City or Town, Stete)

Thus

Registrar

31. Date filed (Month 2 8 1999

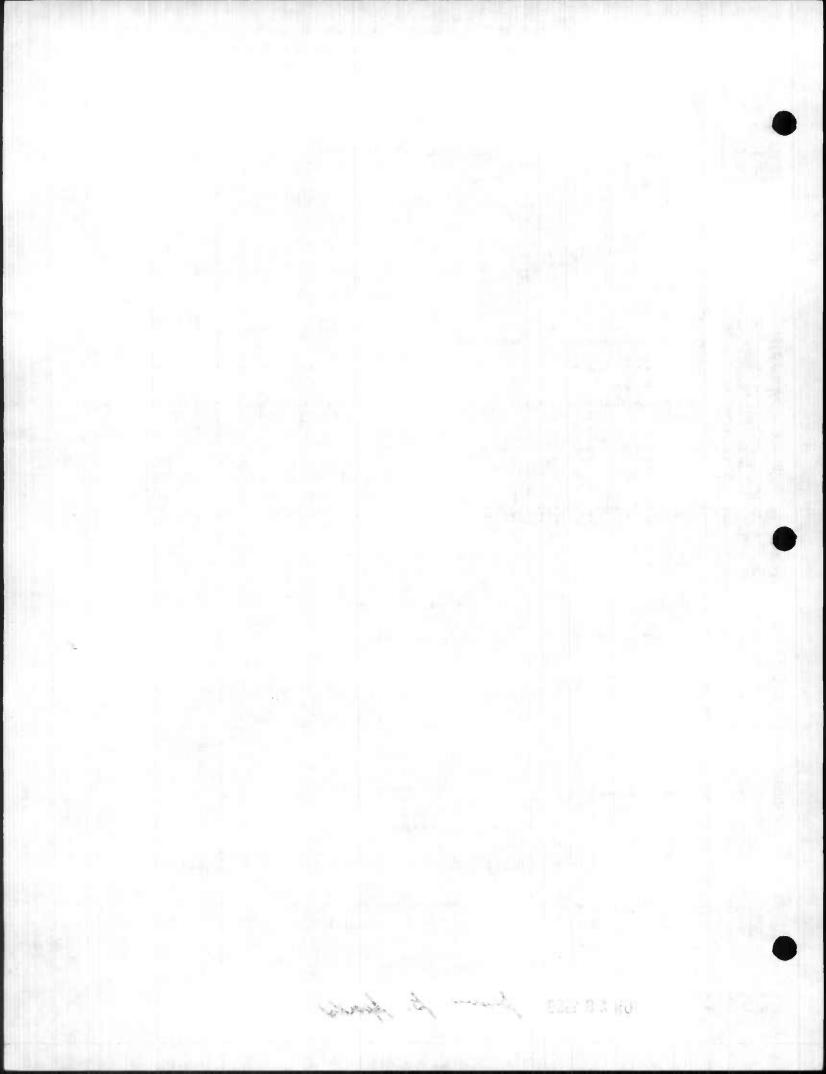
1. Decedent's Name (First, Middle, Last)

4a Facility Name (If not institution, give street and number)

Ellen

Mary

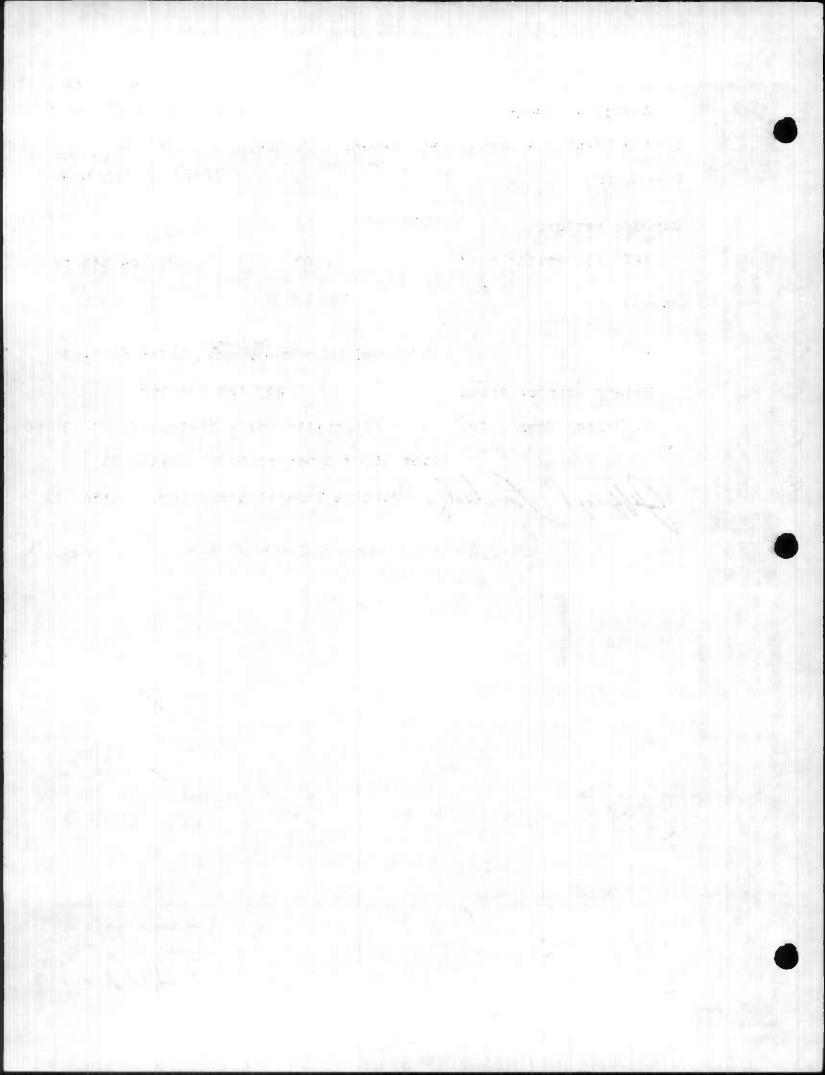
33 Registrar's Signature



	Certificate of Maryland / Department of F	Death	Reg. No.
Physician	1. Decedent's Name (First, Middle, Last) Alex E. Patton	2. Date of De Month	Day Year
/Medical Examiner		JUNE Ib. City, Town, or Location of Deat	20, 1999 11:05 A.M. 4c. County of Death
Examiner	Memorial Hospital	Cumberland	Allegany
Funeral Director	5. Social Security Number 212-24-0560 6. Sex 1 M 2 F 7. Age (In yrs. last birthdey) Months Days	If Under 24 Hrs. 8. Dete of Bir Hours Min. (Month, Da	
Aaryland I show sid at Or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Md Allegany Lonaconing		10d. Inside City Limits 11☑ Yee 2 □ No
Other death with the Marylan there 23e or 28e+1 show short must be notified at Funeral Director	10e. Street and Number 10f. Zip Code 41 Douglas Avenue 2.	1539	10g. Citizen of What Country? United States
1 18 5		ispanic Origin? (Specify Yes or No. n, Mexican, Puerto Rican, etc.)	
15-0 72 h	15. Decedent's Education 16a. Decedent's Usual Occup (Specify only highest grade completed) (Give kind of work done of the complete of the com	during most of working	16b. Kind of Business/Industry
S12	Elementery/Secondary (0-12) College (1-4or 5+) 12 Iffe. DO NOT use retired Accounting		Westvaco
uryland the the thought be the marked other	17. Father's Name (First, Middle, Last) Alexander Patton	18. Mother's Name (First, Middle	
larylan 2 should be and Mental a marked o surretic eve			Cormick
Ma md 2 si ath an 27 is 1 or traus	19a. Informant's Name/Relationship (Type, Print)19b. Mailing Address (StreetJean Patton / Spouse41 Douglas Patton	end Number or Aural Route Numb Ave. Lonaconing	
re, M Health Hem 27 Other tr	20a Method of Disposition 20b. Place of Disposition (Neme of	Date	20c. Location - City or Town, State
altimor nit. Pages artment of ortant: If the injury or o	Description 3 Removal from State 4 Donation 5 Other (Specify) Commetery, cremetory or other please removal from State Frostburg Memorial	Park 6/23/99	Frostburg, MD
Dean Department of the part of	21. Signature of Funeral Service Licensee 22. Neme and Address Boal Funer	111 C	hurch Street rnport, MD 21562
Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin shock, or heart feilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting In death) a. ADVANCED CARCINOMA OF BREA Due to (or as a consequence of):		Interval Between Onset and Deeth August 199
Box 68760, ath certificate be executed attending physician and for use as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		
P.O. nat the de de by the stached Physic	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause give		tobacco use contribute to the cause of death Yes 2 No 3 Probably 4 Unknow
of Vital Records, Physician: The law requires the this certificate has been signed rail director, page 2 should be director, page 2 should be director. TO Be Completed by			an autopsy primed? 24b. Were autopsy findings available prior to completion of ceuse of death?
I Re lav		10	Yes 2 No 1 Yes 2 No
Vital I riclen: The certificate rector, pag	25. Was cese referred to medical axaminer?	28. Place of Deeth (Check only	one)
of very physic this control and direct and d	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Oth	4 U Nursing Homa 5 U Hes	
After function	2 Accident	y at k? Yes 2 No 28d. Describe	how Injury occurred
Division or Attending a strending a strending of the death. I Director: Attending of in by the function certification	3 Suicide 4 Homlcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		Street end Number or Rural Route Number, wn, State)
Division of Vital Re To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time one) 2. Medical Examiner: On the basis of examinetion and/or investigation, in my one and manner stated.	ne, date and place, and due to the pinion, death occurred at the time,	cause(s) and manner as stated. dete end place, and due to the cause(s)
/	29b. Signature and title of certifier 29c. Licens	071	29d. Date signed (Month, Day, Year)
6	D 23 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 625		June 21, 1999 uite 102
ms	Dr. Q. Zaman, Johnson Heights Medical Building	, Cumberland,	
State Registrar	JUN 2 4 1999		

way to want was all

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth 1999 **Physician** 1650 AUSTIN N. ROWAN June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number, Examiner Lorien RIverside Nursing and Rehab. HARFORD Belcamp if Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Hours Min. Yrs. 91 Director 215-16-2216 Usuai Residence of Decedent 5/10/08 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 28s-f: Directo Whiteford Maryland Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 the Medical Examiner must be Berns 23s 4455 Flintville Road Funeral 21160 United States 12. Was Decedent Ever in U,S Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 6 1 Yes 2 No Specify: Specify: á White 3 Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Civil Service Chief Facilities Maintenance 11 other Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be and Mental h marked 2 Nelson Granger Rowan Nancy Ann Wheeler 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son ż 1 and 2 Department of Health reportant: If Item 27 4455 Flintville Road, Whiteford, MD A. Nelson Rowan, 21160 Baltimore, 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages *Burlal 2 Cremetion 3 Remove from State 4 ☐ Donetion 5 ☐ Other (Specify) Slate Ridge Cemetery 6/29 Delta, PA 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximete ne cause on ea ntervai Beti Onset end I) **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es a consequence of) Examiner physician and the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760, 8 Physician/Medical Due to (or es a consequenca of) 88 nse i for 23b. Did tobacco usa contribute to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. ate has been signed by page 2 should be detact 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Was en eutopsy performed? Completed certificate has 2 0 No 2□ No 1 Yes 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) 2 7 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27 Manner of Death 28e. Dete of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Naturai i or Attendin after death. Director; Aft 1 Yes 2 No Accident 6 Could not be determined 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Hospital 24 hours a 29a. Certifier Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical юmpletely Medical Examiner: On the basis of ever and manner stared. (Check only aination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) To the Within 2 29b. Sign N 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)... NOA 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State JUN 28 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** WILLIAM EDWARD ROWAN JUNE 21, 1999 8:00 a.m. /Medical 4s Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5125 WRIGHT AVENUE BALTIMORE N/A 5. Social Security Number 213 - 22 - 3026 If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 12 02 1926 Birthplace (Stata or Foreign Country)
 W. VA 7. Age (In yrs. last birthday) **Funeral** Days Hours XXM 2 F Yrs. Director 72 **Usual Residence of Decedent** the Maryland 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahow adical Examiner must be notified at Yas 2□ No Director MD N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code WITH 5125 WRIGHT AVENUE 21205 U.S.A. deeth v Funeral 14. Race - American Indian, Black, White, atc. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mentel Hyglens. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, in Medical Emminest 1 ☑Yes 2 ☐ No If Yes, Giva Year or Datas: WW 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yas 2 XNo Specify: Specify: P White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Meat Cutter Giant Food 12 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Ada Fleming Peter J. Rowan 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1116 Frenches Avenue, Essex, Md 21237 Sharon Dawson/Daughter 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata Rocky Gap Veterans Cem 4 □ Donation 5 □ Other (Specify) 106/24 Flintstone, MD 22. Nama and Addrass of Facility for Scarpelli Funeral Home, P.A. BRADLEY-ASHTON-MATTHEWS FUNERAL HOME, INC. 2134 WILLOW SPRING ROAD BALTIMORE, MD 21222 23a. Part1. Enter the disease, or complications that caused the dishock, or heart feilure. List only one cause on each inc. Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CARDIOMYOPATH YEURS Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burlel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The lew requires that the death certificate be executed Dua to (or as a consequence of) Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? Dege 2 1 Yas 2 No 1 Yas 2 No of Vital Hospital or Attending Physician: To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case relayed to medical 8 26. Place of Deeth (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 1 Yes 2 No 5 Rasidence 6 □Other (Specify) Certification: To 27. Manner of Death 28a. Data of tnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 Yas 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Data signed (Month, Day, Year) 12

Registrar

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State

Bank St

Baltimore Md 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SILVERDO

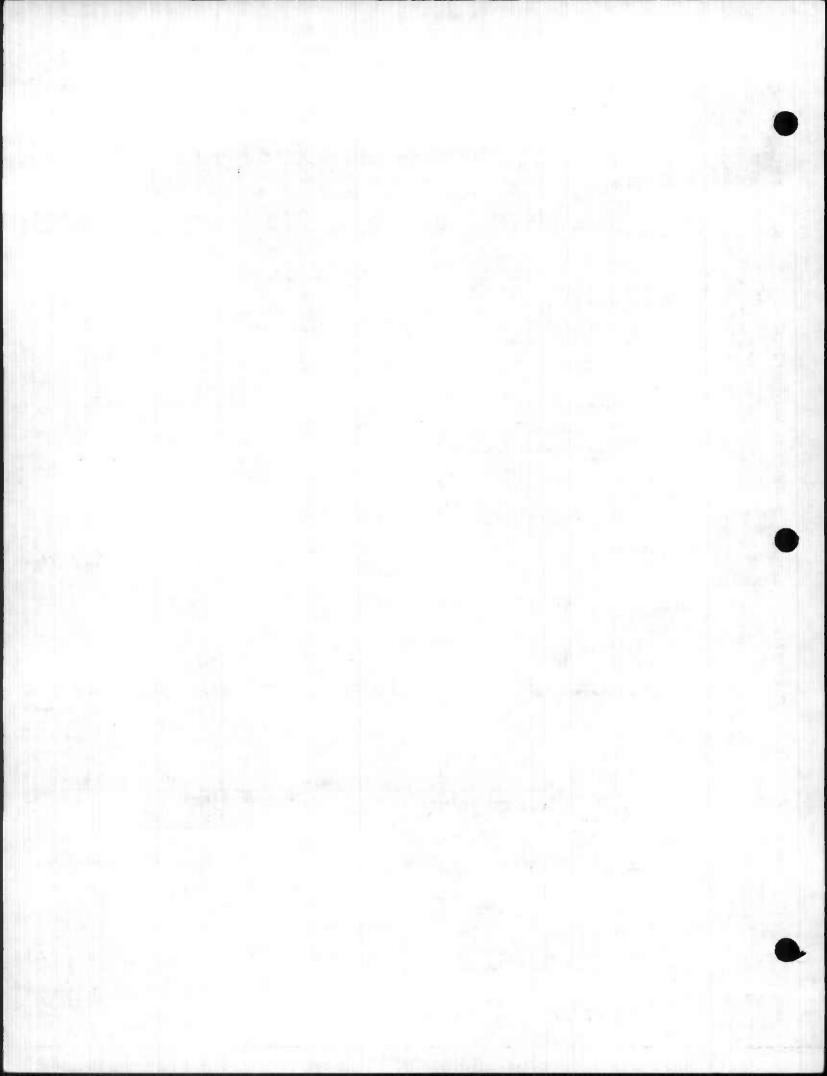
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31. Data filed (Month, Day, Year)

3411

32. Registrar's Signature

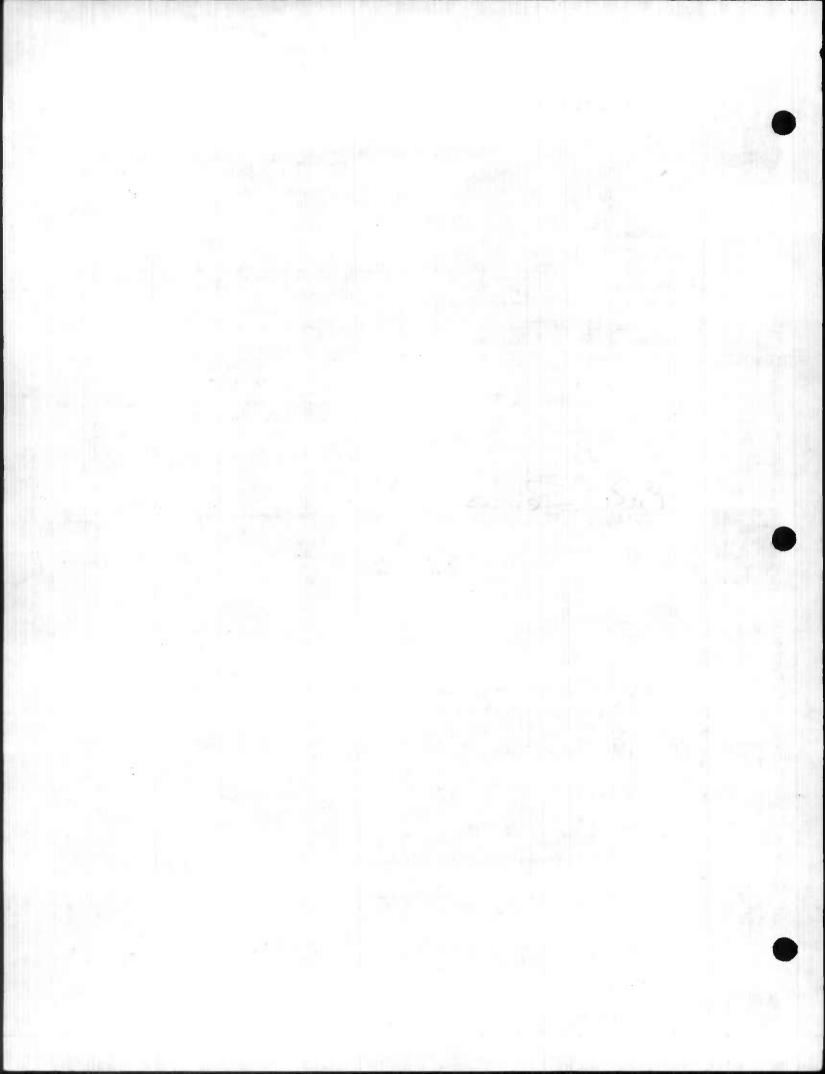


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Year Month Physician CATHERINE DELLA RUSSELL 1999 0215a.m. 16 June /Medical 4a Facility Name (Il not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY CUMBERLAND SACRED HEART HOSPITAL 8. Date of Birth (Month, Day, Year)
2 1920 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours 1 M 2 F Yrs. 78 MARYLAND Director 213 16 9602 Usual Residence of Decedent with the Meryland ahow 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits pernit. Pages 1 and 2 should be filed within 72 hours after deeth with the Meryle Department of Heelth and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f ahow phy injury or other treumatic avent, the Medical Examiner must be notified an once. 1 ☐ Yes 2 No Director MARYLAND ALLEGANY FROSTBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19607 BUSKIRK HOLLOW ROAD, SW 21532 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ᡚ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify à 3X Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 HOMEMAKER OWN HOME Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 MARSHALL LANCASTER ALICE CARTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RITA FIDLER, DAUGHTER 138 W. MAIN ST., FROSTBURG, MD 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State FROSTBURG MEMORIAL PARK 6/18/99 FROSTBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme and Address of Facility 21. Signature of Funeral Service Licensee 0 SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Examiner ician and burial-transit The lew requires that the death certificate be executed Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician a the burial Box 68760. Physician/Medical Due to (or as a consequence of): attending p P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Division of Vital Records. þ 50 phoone 24b. Wera autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Attending Physician: director. 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4□ Nursing Home 5□ Residence 6 □Other (Specify) Certification: To 1 Yes 2 No After this funaral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending 1 (Netural after death.
Director: Aft investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 illedical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 3 D2537 1999 June 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mis M.D., 912 SETON DRIVE, CUMBERLAND, MD 21502 GEORGE M. BREZA, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 2 3 1999

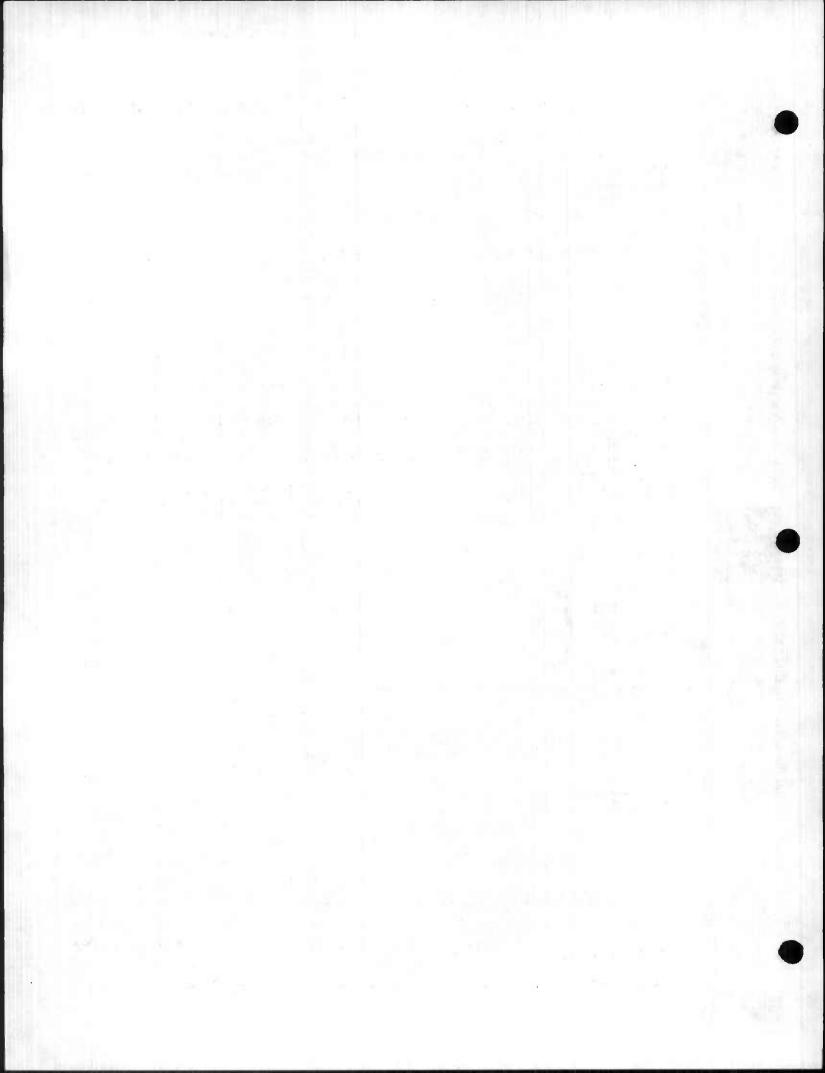
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

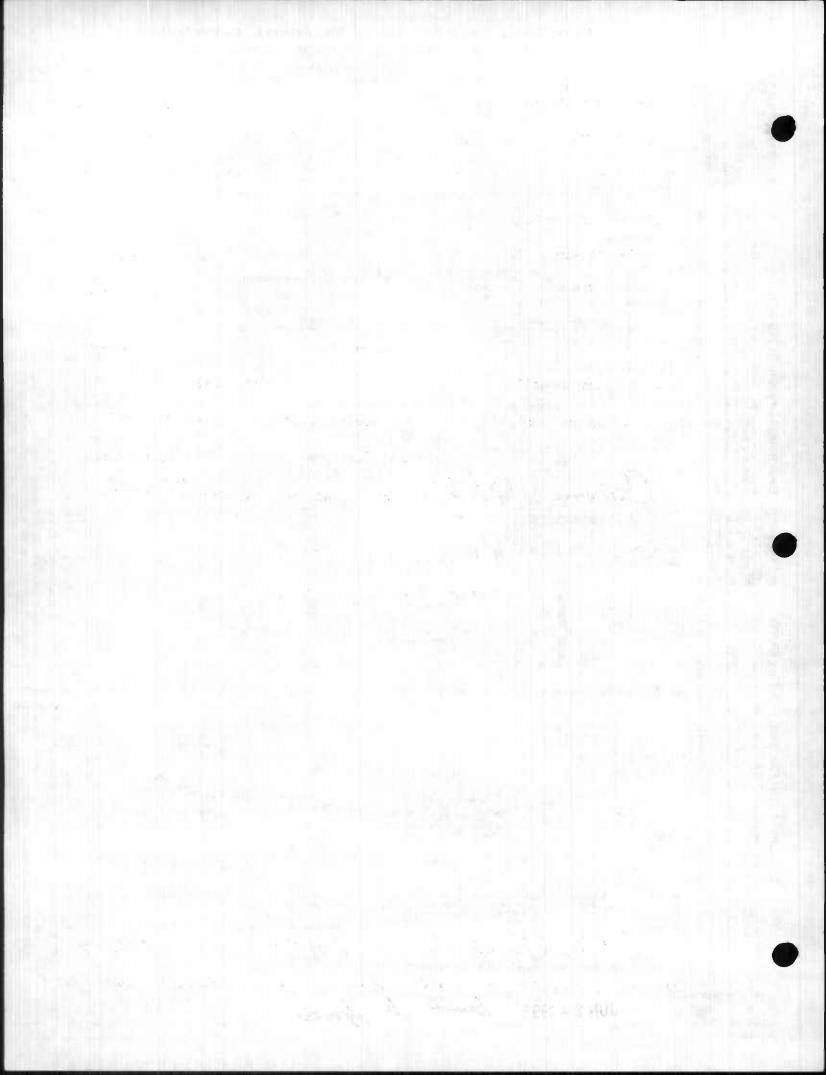
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Day **Physician** CHARLES F. SOWERS, SR. JUNE 21 1999 8:20 am /Medicai 4a. Fecility Neme (If not institution, give street end number) 4b. Cify. Town, or Location of Death 4c. County of Death Examiner SACRED HEART HOSPITAL CUMBERLAND ALLEGANY | If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | JAN • 5 , 1921 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F MARYLAND 220-10-4170 78 Yrs. Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show Director MD ALLEGANY CUMBERLAND X□ Yes 2□ No the 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 698 THOMPSON AVENUE Herns 23a 21502 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. efter 1)X☐ Yes 2☐ No If Yes, Give Year or Detes: W.W.II 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "naturel", or 1 ☐ Yes 2 ☑ No Specify: à Specify: U.S.A. 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiena. Important: if Item 27 is merked other than "any fijury or other traumatic event, tre Magnet. Elementary/Secondary (0-12) College (1-4or 5+) 12 P.P.G. SUPERVISOR 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) HARRY F. SOWERS ELIZABETH DYLING 19e, Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) CHARLES F. SOWERS, JR. /SON 12202 HOLLOW TREE LANE, FAIRFAX, VA 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State SUNSET MEMORIAL PARK 6/24/99 CUMBERLAND, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 Greene St., Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner The law requiras that the death certificata be executed physician and s the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequenca of) Box 68760, Due to (or as a consequence of) use as P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by to 1 Yes 2 No 3 Probably 4 Unknown Records. by 24b. Were autopsy findings aveilable prior to completion of cause of death? page 2 should Completed 24e. Wes an autopsy performed? certificata 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this the funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After Division 5 Pending Investigation 1 Neturel daath. 1 Yes 2 No 2 Accident after daath 6 Could not be determined 3 ☐ Sulcide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled the Hospital 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete end placa, end due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical 29e. Certifier (Check only one) 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) D08377 MID andiai 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Mo Uriel Velandia, M.D. - 902 Seton Drive, Cumberland, MD 31. Dete filed (Month, Dey, Year)
JUN 2 3 1999 32. Begistrer's Signature State Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Name (First, Middle, Last) Certificate of Death 2. D					2. Dete of Dee	Reg. No. 3. Time of Death			
Physician	Grace Wilhelmine Speak					June	Pay 1	999	2:30PM	
/Medical Examiner	4e Facility Nama (If not institution, give				4b. City, Town, or Lo	cation of Deeth				
LAGIIIIICI	Frederick Memorial Hospital Frederi				ick	Frederick				
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. lest 178-24-8605 1□ M 2⊠ F 71			Months Deys	If Under 1 Yeer If Under 24 Hrs. 8. Date of Months Deys Hours Min. Dec.		th y. Yeer) 9. Birthplace (State or Fore Country) Maryland		try)	
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	10e. Street end Number 10f. Zip Code						10g. Citizen of Whet Country?			
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	Robert L. Speak/ husband 12456 Woodsboro Pike					-	ymar, MD 21757			
	20e. Method of Disposition 1 \(\begin{align*} \text{ZBuriel 2 \subseteq Cremation 3 \subseteq Removel from State} \) 4 \(\begin{align*} \text{Donetion 5 \subseteq Other (Specify)} \) 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) \) Fairmount Cemetery 6				Dete 5/22/99	20c. Location - City or Town, State 9 Libertytown, MD				
Depertment Par Important: any Injury	21. Signeture of uneral Service Licer	O. Wart	Den	22. Name end Addres 404 S. Ma	ess of Fecility Har in St.	tzler F Woodsbo	uneral	Home 21798	}	
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or Attending Physician: Tha law requiviter death. Director: After this certificate has been in by the funeral director, paga 2 should by the funeral director. Paga 2 should be the fill cation: To Be Completer						en eutopsy med?	co	ere autopsy findings eilable prior to mpletion of cause death?		
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Hospital or At 24 hours effer of Euneral Directives of Ference of Ferenc	(Check only 2 Medical Exam	29b. Signature and title of certifier // 29c. License number					29d. Dete signed (Month, Dey, Year)			
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		Funeral Director		Fallston Gene 5. Social Security Number 6. 219–36–0212			lest birthdey)	f Under 1 You	Fallsto eer If Under 24 Hrs. ays Hours Min.	8. Date of Birtl (Month, Da)	h v, Year)		(State or Foreign
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bet		the Marylan 28s-f show notified at	ctor	10a. State 10b. County Maryland Harf	ord		ty, Town or Locat treet	ion					nside City Limits Yes 21 No
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中田	020	oun after dea nai', or items Examiner in	by Funeral	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorcad	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	es? No	If Y	s Decedent es, specify (Yes 2)(2)	of Hispenic Origin? (Spe Cuben, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Rec Bla Specif	ce - American in ck, White, etc.	
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N	Baltimore,	nit. Pages artment of ortant: If its injury or o		1 By Burial 2 □ Cremation 3 4 □ Donetion 5 □ Other (Special Control Cont		ate	nory Ce	ory or other	place)	/28	Stree		otate
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AK	0	the d	hys	Part II. Other eignificant conditione				rlying cauae	given in Part i.	23b. Did to			cause of death?
		ires that the death cei signed by the attendir d be detached for use	by P	dubete	9					' '	20/10	3 Probably	4 Olikliowii
F	Vital Records,	aw requisible been 2 should	Completed	channe	reno	Popu	ilung			24e. Wes e perfor	en autopsy med?	availebi	utopsy findings e prior to ion of cause ?
3	<u> </u>	The ate h	Con						å.	1□ Y	es 20 No	1 ☐ Yes	S □ No
AGU	/ita	ician: The lav certificate has rector, page 2	Be	25. Was case referred to medical examiner?					28. Place of Death	(Check only o	ne)		1
Y	fo	Physic this c	2	1 Yes 2 No	Hospital:		ER/Outpatient	3L DON	Other: 4 Nursing Hor				
1/2	Division	utending Physician: The L death. ctor: After this certificate he y the funeral director, page	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		Injury Day Year)	28b. Time of Injury		njury et Work? 1 □ Yes 2 □ No	28d. Describe h	low injury occur	rred	
	DIVÎ		Certification:	3 Suicide 6 Could not l 4 Homicide determined	289. Place 0	f Injury - At ho , etc. <i>(Specif</i>	ome, ferm, street,	factory, off	ice	28f. Location (S City or Tow	Street and Numl m, State)	ber or Rural Rou	ite Number,
		To the Hospital or within 24 hours efter To the Funeral Director Completely filled in	edicai	29e. Certifier (Check only one) Certifying Pl	nyeician: To the bas miner: On the bas end manne	Is of examina	wledge, deeth oc tion and/or invest	curred at th	e time, date end pleca, eny opinion, death occurre	end due to the ded at the time, o	cause(s) and medate and place,	enner es stated and due to the	cause(s)
		To the within 2 To the comple	M	29b. Signature and title of certifler				29c. Lic	ense number	2	29d. Date algne	d (Month, Day,	Year)

10 State Registrar 30. Name and address of peraon who completed cause of death (Item 23a) (Type, Print) Dov. D 5. Down 615 wimacPhA.

31. Date filed (Month, Day, Year) JUN 2 8 1933

32. Registrar a Signeture

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June 27, BOF

Jeff

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William William Services

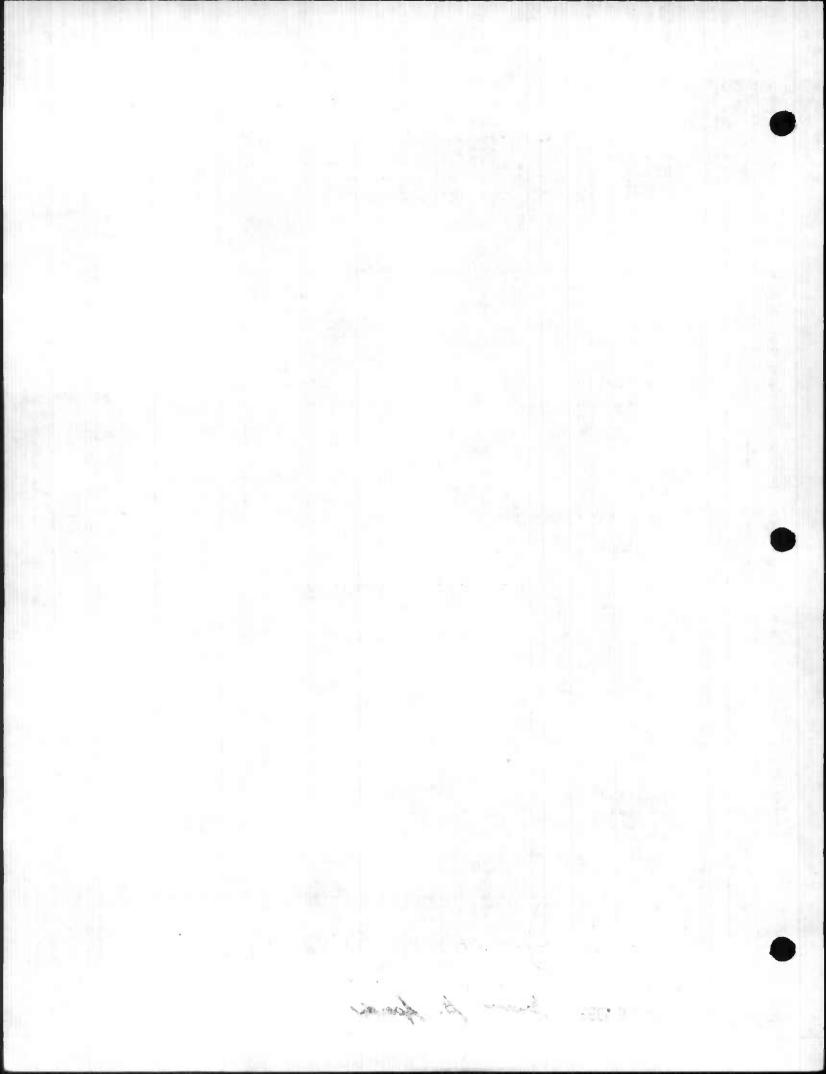
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	Decedent's Neme (First, Middle, Last)		rtificate of l		Reg. No.	3. Time of Death
Physician /Medical	James F.	Tayl	or		onth Day Y	3:45 AM
Examiner	4a Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL & MEDICA			b. City, Town, or Location CUMBERLAND	of Death 4c. County of ALLEGAI	
Funeral Director	5. Social Security Number 6. Sex 7. Ag 705-12-2127 X M 2 F 7. Ag Usual Residence of Decedent	ge (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	Hours Min. 8. De	onm, Day, Yearl). Birthplace (State or Fore Country)
MON.	10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Lim
ms 23a or 23a-f show cmust be notified at neral Director	WV Mineral	Wi	ley Ford			1 Tes 2
Director Dir	10e. Street and Number Box 27		10f. Zip Code	26767	10g. Citizen of Wh	at Country?
Important: If them 27 is marked other than "natural", or frems 23s or 28s-1 shot any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Meritel Stetus 1 Never Married 2 Merried 12. Wes Decedent Armed Forces? 1 Yes 2 Merried 1 Yes 3 Merried	No	If Yes, specify Cuba	ispanic Origin? (Specify Y In, Mexican, Puerto Rican, Specify:	es or No- etc.) 14. Race - Biack,	American Indian, White, etc.
d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 Yes 2 No			white
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4ors)	(Give	DO NOT use retired	during most of working	Railroad	
To Be C	17. Father's Neme (First, Middle, Last) Moses Taylor				, Middle, Maiden Sumame) emley)	
-	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Address (Street 27; Wiley	and Number or Rural Rou	te Number, City or Town, St	ate, Zip Code)
	W. Rita Heavner - friend	20b. Place of Dispo			26767	hu a Taura Chaha
8	1 XBurial 2 □ Cremetion 3 □ Removel from State	cemetery, cre	matory or other place			
	4 □ Donetion 5 □ Other (Specify) 21. Signeture of Funeral Service Licensee			metery 6/2 Si ^{of} Funeral	29/ Parsons	S, WV
any li	> 4 Toholor I Ma		-	ind, Maryla		
ian	23a. Part1. Enter the disease, or complications that cause shock, or heart feitura. List only and cause on each in	drie death. Do not en	ter the mode of dyin	g, such as cardiac or resp	viratory arrest,	Approximete Interval Between Onset and Deet
al er	Immediate Cause (Finel disease or condition resulting in death) CARDIO	MYOPATHY				1 YEAR
ě		OSCLEROTIC		CEACE		10 VEAD
Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of):	JEROE		10 YEARS
Iclan	Pert II. Other significant conditions contributing to death b	net and requiling in the s	indechina cause nic	on in Part I	3b. Did tobacco use contr	ibute to the cause of de
Physician/M	Port II. Other arginiscant contations contributing to degin b	or nor resouring in the c	alderlying cause give	all Irail I.		Probably 4 Unk
Completed by	4			2	4a. Was an autopsy performed?	24b. Were autopsy findir aveilable prior to completion of cause of death?
Com					1 ☐ Yes 2 € No	1 Yes 2 No
Be Com	25. Wes case referred to medical axaminer? Hospital:		oth Oth	26. Place of Death (Che	ock only one)	
ion: To Be (27. Manner of Death 28a. Date of Inju	ry 28b. Time o	III JU DON	4 Nursing riome :	5 ☐ Residence 6 ☐ Other Describe how injury occurred	
Certification:	1 02 Natural 5 Pending (Month, Da 2 Accident investigation 3 Suicide 4 Homicide (Month) Description (Month, Da 2 Place of Injurishing, etc.)	jury - At home, farm, st c. (Specify)	M 10	Yes 2 □ No 28f. L	ocation (Street and Number ity or Town, State)	or Rural Route Number,
Medical Certifical	29e. Certified 15 Certifying Physician: To the best (Check only 2 Medical Examiner: On the basis of and manner st	examination and/or in			e to the cause(s) and mann the time, date and place, an	
20	29b. Signeture and title or certifler	W	29c. Licens	2-17 g	JUNE 26	
		death (Item 23a) (Type,				
44	W. GUY FISCUS M.D., 500 MEI 31. Date filed (Month, Day, Year)		NUE, CUMBI	ERLAND, MD 2	1502	
State gistrar	JUN 2 8 1999	P. 10	ade	/		

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician William** June 30 James Truly 1999 4:40AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sacred Heart Hospital Cumberland **Allegany** 8. Date of Birth
[Month, Day, Year]
June 5, 1930 5. Social Security Number 6. Sex. 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 217-28-0617 69 Director Usual Residence of Decedent the Maryland 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow 7 is marked other than "natural", or flems 23s or 28s-f show traumatic event, the Medical Examinar must be notified as **Allegany** Md Lonaconing Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 36 Island St. 21539 USA Funeral death 12. Was Decedent Ever in U.S.
Armed Forces?
1 Dayea 2 □ No Korean
If Yes, Give
Year or Dates: Conflict Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examples once. 1 Never Married 2 Married 1□Yes 2NNo specify.White Baltimore, Maryland 21215-0020 Specify þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Bar Food 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) William James Truly Sr. Lula Belle Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Vickie Shingler-Daughter 19817 Big Lane, Midland, Md. 21542 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July 2. Burial 2 Cremation 3 Removal from State 1999 Sunset Memorial Park Cumberland, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lichhorn—McKenzie Funeral Home P.A. Lonaconing, Md. 21539 Lonaconing, Md. 21539

Lant. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, mode, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Arteriosclerotic heart disease disease or condition resulting in death) Uk yrs Examine Due to (or as a consequence of): Physician/Medical Examiner Diabetes g physician and as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or es a consequence of): USB I Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. Yee 2 No 3 Probably 4 Unknown Chronic obstructive pulmonary disease Division of Vital Records, Completed by Aprial fibrillation 24b. Wera autopsy findings evailable prior to 24a. Was an autopsy performed? Post CVA completion of cause of death? page 2 s 1 ☐ Yas 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After or Attending 5 Pending investigation death. 1 Yes 2 No 2 ☐ Accident Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 24 hours after of Funeral Director 4 ☐ Homicide Hospitai Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

It is the course of the cause(s) and manner as stated.

It is the course of the cause(s) and manner stated. edicai 29a. Certifier completely (Check only one) To the F 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Dpty Me Ex D 09157 June 30 1999 11 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) THAY 124 w 3rd st Paul Snow, M.D. Cumb Md 21502 31. Date filed (Month, Day, Year) 2. Registrar's Signatur State 0 2 1999 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First Middle Last) 2. Dete of Death **Physician** JUNE JUNE 1999 2:00 AM ELEANORA ELLEN CONTEE TEMPLEMAN /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 6680 POMFRET ROAD POMONKEY CHARLES If Undar 1 Yaar | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) 9. Birthplece (State or Foreign **Funeral** 1□M 2\F Days Hours Yrs. 578-54-8399 93 Director APRIL 16,1906 MARYLAND Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director MARYLAND CHARLES POMONKEY 10e. Street and Numbe 10f. Zip Coda 10g. Citizen of Whet Country? 6680 POMFRET ROAD 20646 UNITED STATES / LA PLATA, MD Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Yeer or Detes: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, Bleck, White, etc. 1 Navar Married 2 Married 1 ☐ Yas 2 No Specify: Specify: BLACK Ď 3 Widowed 4 □ Divorced Completed 15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 6TH GRADE DOMESTIC WORKER PRIVATE permit. Peges 1 and 2 should be fille.
Department of Health and Mental Hygi important: If Item 27 is marked other any Injury or other traumer. 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be THOMAS CONTEE IDA BARNES CONTEE 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Streat end Number or Rurel Route Number, City or Town, State, Zip Code) SHIRLEY E. KING / DAUGHTER 6680 POMFRET ROAD, LA PLATA, MARYLAND 20e. Method of Disposition 20b. Plece of Disposition (Nema of cametery, cremetory or other plece) 20c. Location - City or Town, Stata Burlal 2 Cremetion 3 Ramoval from Stete 4 ☐ Donation 5 ☐ Other (Specify) SHILOH CHURCH CEMETERY 7/5/99 NEWBURG, MARYLAND 21. Signature of Funeral Service Licensee 22. Name end Address of Facility
THORNION FUNERAL HOME, P.A. IA C. THORNTON JOHNSON M00583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haer failure. List only one cause on each line. Approximate Interval Betw Onset end Deeth **Physician** /Medical Immediete Causa (Final omos diseese or condition resulting in death) Examiner Dua to (or as a consequenca of): Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Diseesa or Injury that initieted avents resulting in death) Last Due to (or es a consequença of): Physician/Medical the Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Ware autopsy findings aveileble prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical axaminer? 26. Placa of Death (Check only ona) 1 ☐ Yes No Other: 4 Nursing Home 5 Aesidenca 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Death 28e. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 1 Naturel 5 Panding Investigation 1 Yas 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and plece, and due to the cause(s) and menner as stated.

Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Certifier Medical (Check only one) 29b. Signature and time of certifie 29c. Licensa number 29d. Date signed (Month, Day, Year)

State Registrar

the Maryland

filed within 72 hours efter death

Maryland 21215-0020

Baltimore,

The law requires that the death certificate be executed

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or Attending Physician:

Box 68760.

Division of Vital Records, P.O.

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31. Date filed (Month, Day, Year)

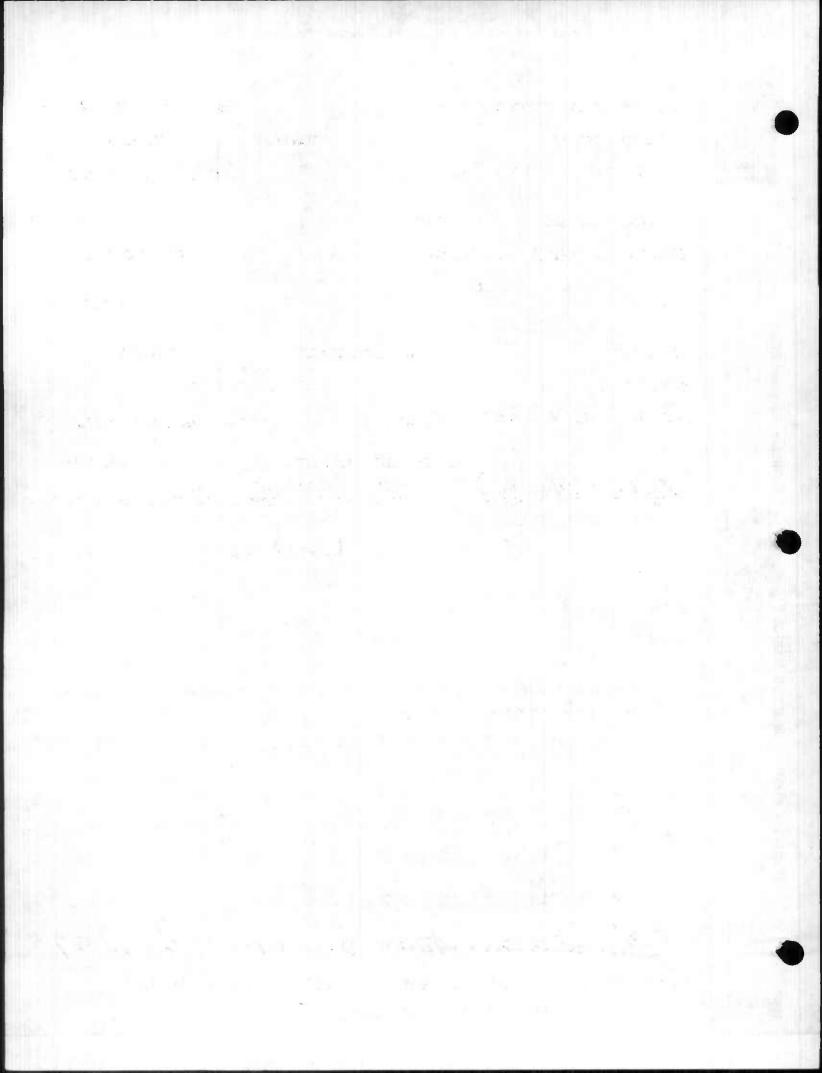
JUN 3 0 1999

30. Neme end eddrass of person who completed cause of death (Itam 23a) (Type, Print)

PAUL E. PRITCHETT, M.D. 118 LA GRANGE AVENUE, LA PLATA, MARYLAND

32. Registrer's Signature

20646



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** 30 1999 6:00AM SALLY ANN WADE JUNE /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LAPLATA CENTER GENESIS ELDERCARE LA PLATA CHARLES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days 98 Yrs. 215-38-3952 Director MARCH 16, 1901 MARYLAND Usual Residence of Decedent tha Menylend 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 2 No CHARLES HUGHESVILLE Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Cifizen of What Country? 72 hours after death with 15572 PRINCE FREDERICK ROAD 20637 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes, 2 W No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 ☐ Married Maryland 21215-0020 Specify: BLACK 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER DOMESTIC other traumatic avent. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be finance and Mental Fire marked of JOSEPH R. WADE MARY M. GROSS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pegas 1 and 2 si Department of Health and Important: If item 27 is n any injury or other traur LENA GARDINER / FRIEND 15174 HUGHESVILLE MANOR DRIVE HUGHESVILLE, MD 20637 more, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burlat 2 Cremation 3 Removal from State ST. MARY'S CHURCH CEMETERY7/3/99 BRYANTOWN, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21, Signature of Funeral Service Licenses 22. Name and Address of Facility ADAMS FUNERAL HOME AQUASCO, MARYLAND 20608 23a. Part1. Enter the diffuse, or complications that caused the death shock, or heart failers. List only one cause on each line. Approximate Interval Between Onset and Death infor the mode of dying, such as cerdiac or respiratory arrest, **Physician** /Medical tmmediate Cause (Finel disease or condition resulting in death) Examiner Examiner the daath certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as e consequence of): buriel physician s tha buriel Box 68760. Physician/Medical Due to (or es e consequence of): 80 ed by the attending i 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o signed by t 1 Yes 2 No 3 Probably Unknown that by Records, law requires 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? peen completion of cause of death? has paga 2 The 1 Yes 2 No this cartificate of Vital Physician: director, 25. Was cese referred to medical exeminer? Be 26. Place of Death (Check only one) 1 Yes 2 Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funaral 28d. Describe how Injury occurred 27. Mannet of Death 28b. Time of 28c. Injury at Work? Certification: Aftar Attanding 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation daath. i or Attand aftar daati Director: tha 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 24 hours a Funeral C Certifying Phyalcian: To the best of my knowledge, which occurred at the time, date and place, and due to the cause(s) and manner as stated.

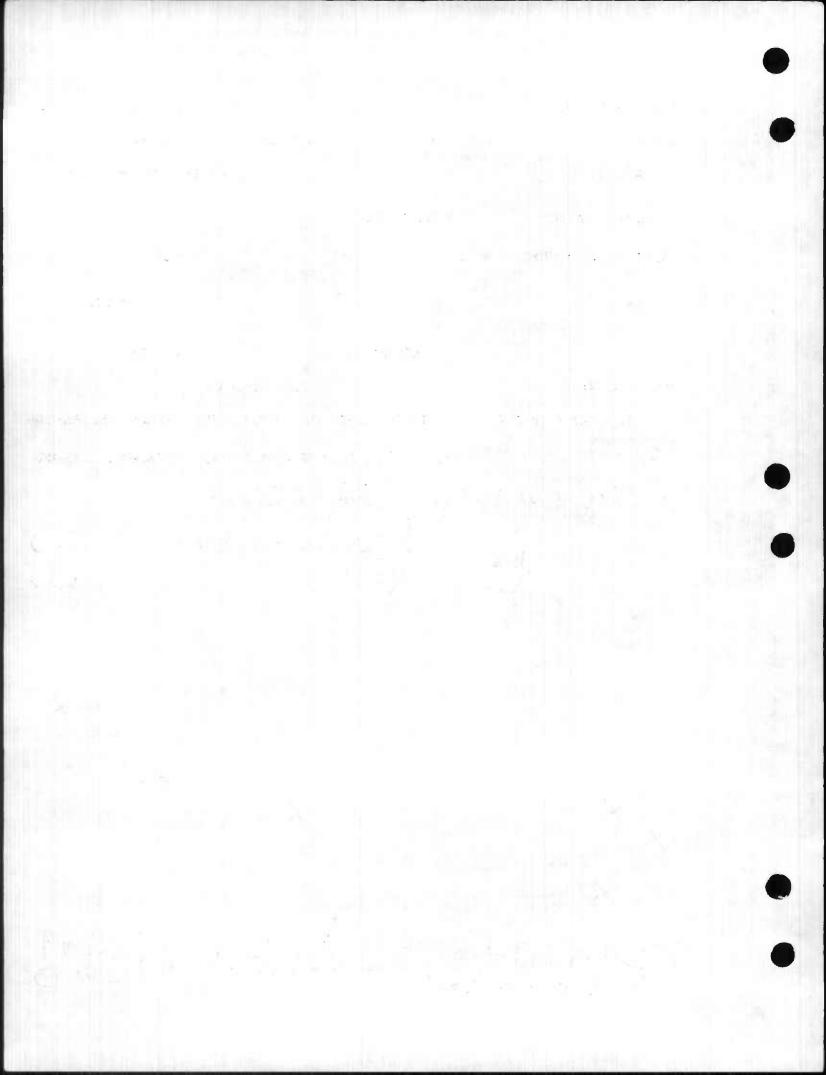
2 Medical Examinar: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely In my opinion, death occurred at the time, date and place, and due to the cause(s) To the 7 within 2 To the 7 29d. Date signed (Month Pay, Year) 29b. Signature and title of certifie 31. Date filed (Month, Da) 32. Registrar's

Registrar

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Signat Present.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Year **Physician** DAVID MITCHEL JUNE 26 1999 8:00 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL & MEDICAL CENTER ALLEGANY CUMBERLAND If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 11XM 2□ F 76 Yrs. Director JULY 2 1922 217-18-4230 MARYLAND Usual Rasidence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits show r than "natural", or flams 23e or 28a-f shor the Medical Examiner must be notified at 1 Yas 2 No MARYLAND ALLEGANY FROSTBURG Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11101 WELSH HILL 21532 U.S.A. Funeral 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 Tyes 2 No If Yes, Give WW11 Year or Dates: 1 ☐ Never Married 2 ☑ Married b 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: WHITE à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry 22 Hygiere. Elementary/Secondary (0-12) College (1-4or 5+) OWNER WATSON AGENCY permit. Pages 1 and 2 should be the Department of Health and Mental Hy Important: If Item 27 is marked offth any fritury or other treumetic event 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 C. GLENN WATSON ETHEL MAE SWAUGER 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE McMILLAN DAUGHTER 216 S. FIRST STREET LAVALE, MARYLAND 21502 20b. Place of Disposition (Name of 20c. Location - City or Town, Stata 20a. Method of Disposition Data etery, crematory or other place) 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) HILLCREST CEMETERY JUNE 28 1999 CUMBERLAND MARYLAND 21. Signature of Funeral Service Licens 22. Name and Address of Facilit MERRITT-ADAMS FUNERAL HOME X 404 DECATUR STREET CUMBERLAND MARYLAND ations that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part1. Enter the disease, or conshock, or heart failura. List only Approximata Intervel Between Onset and Death **Physician** /Medical Immediata Cause (Final PARKINSONS DISEASE 10 years disaasa or condition rasulting in death) Examiner Due to (or as a consequence of): Examiner PNEUMONIA 2 weeks physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): DAVID WATSON 217-18-4230 Division of Vital Records, P.O. Box 68760 8 an/Medical Due to (or as a consequence of): 987 Physici ed by the s Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy tindings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? has 1 Yes 2 No 1 Tyes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 10 this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of After 5 Pending invastigation death. 1 Yes 2 No 2 Accident or Attendation of the death of 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stele) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated. 29a. Certifier Cai To the Hosp within 24 ho To the Fune completely fi (Check only one) fination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to tha cause(s) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifier 21 June 29, 1999 D 36766 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) VIK POONAI M.D., 920 NATIONAL HIGHWAY, LAVALE, MD 21502 KLO 31. Data filed (Month, Day, Year) 2. Registrar's Signature JUN 29 1999

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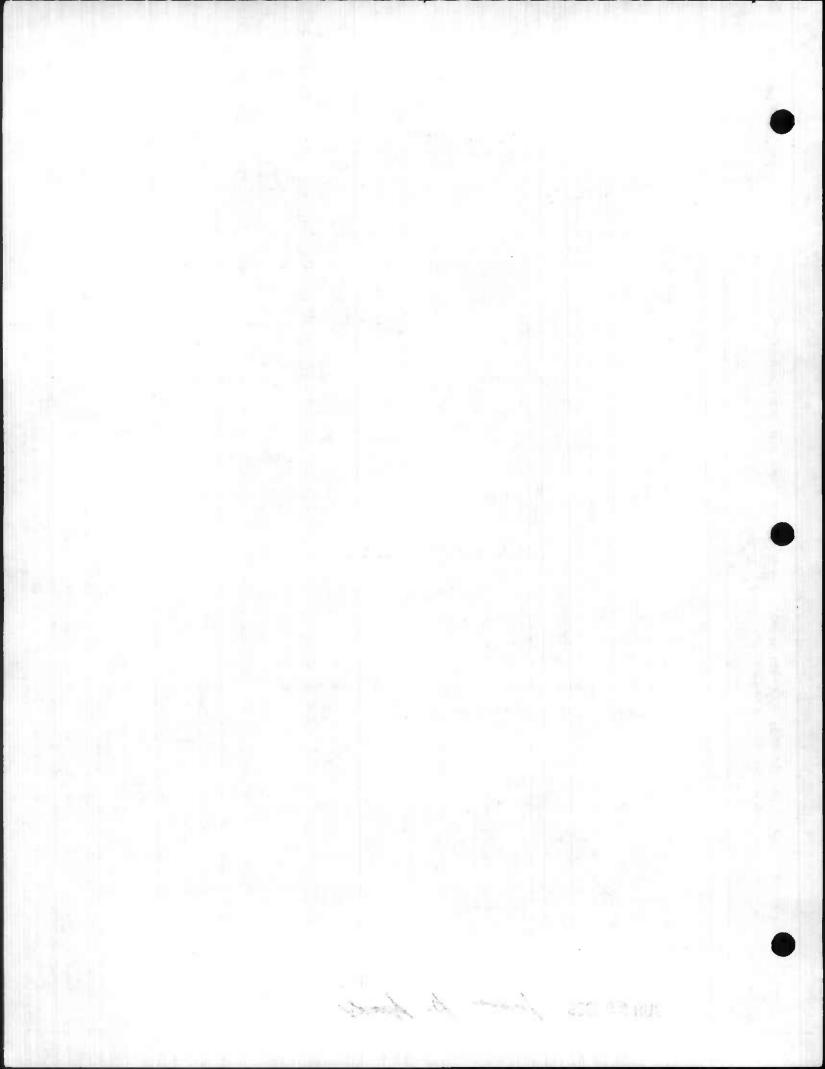
Registrar

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ician	1. Decedent's Name (Fit							2. Date of D Month	Day Day	Year 3. 7	ime of Deeth
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niner	4a Facility Name (If not MEMORIAL H(יבס	1.00	4b. City, Town, or I CUMBERLAI		4c. County		
	5. Social Security Number	er 6. Sa	1x 7. A	ga (in yrs. las	-	If Under 1 Yeer	If Under 24 Hrs.	9 Date of B	inth	O Birtheless /	Steta or Fore
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		c. County		10c. City,	Town or Lo	cation				10d. In:	side City Lim
oto	MD	Alle	gany		Cur	mberlan	d			15	Yes 2 🗆
al Director	10e. Street and Number 619 N. Ce		Street			10f. Zip Code	21502		10g. Citizen of V USA	Vhat Country?	
by Funeral	11. Marital Status 1 Never Married Widowed 4		12. Was Deceden Armed Forcas 14 Yes 2 If Yes, Give Yaar or Datas	? No		Vas Decedent of I Yas, specify Cub	tispanic Origin? (S an, Mexican, Puert Specity:	pecify Yea or No Rican, etc.)	-	e - American Ind ck, White, etc. white	fian,
Be Completed	(Specify or	Decedent's Edu	de completed)		16a. Deced (Give	lent's Usual Occup kind of work done DO NOT use retire	pation during most of wor d)	king	16b. Kind of Bu	usiness/induatry	11-2
mo	Elementary/Secondery	y (0-12)	College (1-4or	5+)		red Mec			Old Exp	port B	rewer
Se C	17. Father's Neme (First								e, Maiden Suman	16)	
10	William V						Mary	(nmn)	16 11 15		
	John C We	eisenm	ype Print) iller J	r	19b. Mailin 619 1	y Address (Street	and Number of Rure Stree	et; Cun	ber, City or Town, berland	State, Zip Code	21502
	20a. Method of Dispositi	on			ce of Dispos	sition (Neme of natory or other pla	ce)	Date	20c. Location -	City or Town, S	tate
17	1 Suriel 2 Cre 4 Donation 5 D			9			ial Gar	17/01/	LaVale	e. MD	
9	21. Signature of Funeral	Service Licens	100 A	۸۸			Ist' Frune:				
8	Yioho	las =	MA	Dell	, (Cumberl	and, Ma	ryland	21502	2	
	23a. Part1. Enter the die shock, or heart fail	sease, or comp lure. List only o	restions that cause ne cause on each	the death.	Do not ante	er the mode of dyi	ng, such as cerdiad	or respiratory	arrest,	Inten	oximate val Between
	Immediata Causa (Final									Onse	et end Deat
	disease or condition resulting in death)		a. ACUTE			Y FAILUR	.E			1	HOUR
ě			A CITITE	Due to (or e			A TT LIDE			1	*******
Examiner	Sequentially list condition	ons,	b. ACUIE	Due to (or a		HEART F	AILURE			3	HOUR
EX	Sequentially list condition if any, leading to immed ceuse. Enter Underlying Cause (Disease or Injury)	liate	ACUTE	RENAL	FATLU	RE				12 1	DAYS
edicai	thet initiated events resulting in deeth) Lest		c. Trouzz	Dua to (or a							76.10
			d								
by Physician/M	Part II. Other significant	conditions	ntributing to death	but not resulti	ng in the ur	derlying cause di	ven in Part I	23h Di	d tobacco uss co	ntribute to the c	ause of de
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by	CHRONIC OF	BSTRUCT	LVE PULMO	NARY D	ISEAS	E		/			
Completed									is en autopsy formed?	24b. Were eu available	topsy findir prior to on of cause
nple										of death	?
Co								10	Yes 2 No	1 🗆 Yes	212 No
0	25. Was case referred to examiner? 1 ☐ Yes 2 No	-	Hospital: 1 1 Inpat			Ott	26. Place of Dea				
Ë	27. Menner of Death		28a. Date of Inj	ury 2	VOutpatien	28c. Inju			sidence 6 □Oth e how injury occur		
atio	⊉ Accident	Pending investigation	(Month, D	ey rear)	Injury		Yes 2 □ No				
	3 ☐ Sulcide 6 [4 ☐ Homlcide	Could not be determined	28e. Plece of Ir building, e	njury - At hom tc. (Specify)	e, farm, atro	et, factory, office			(Street and Numb own, State)	per or Rurel Rou	te Number,
Ö	29e. Certifier 1	Certifying Phy	sicism: To the best	of my knowle	edge, deeth	occurred at the timestigation in my r	me, dete and place	, end due to th	e ceuse(s) and me	enner as stated.	ause(s)
Ca	one)	,	and manner s					22 27 1110 11111			
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100	29b. Signatura and title of	396				D2333	7		2000	12	*
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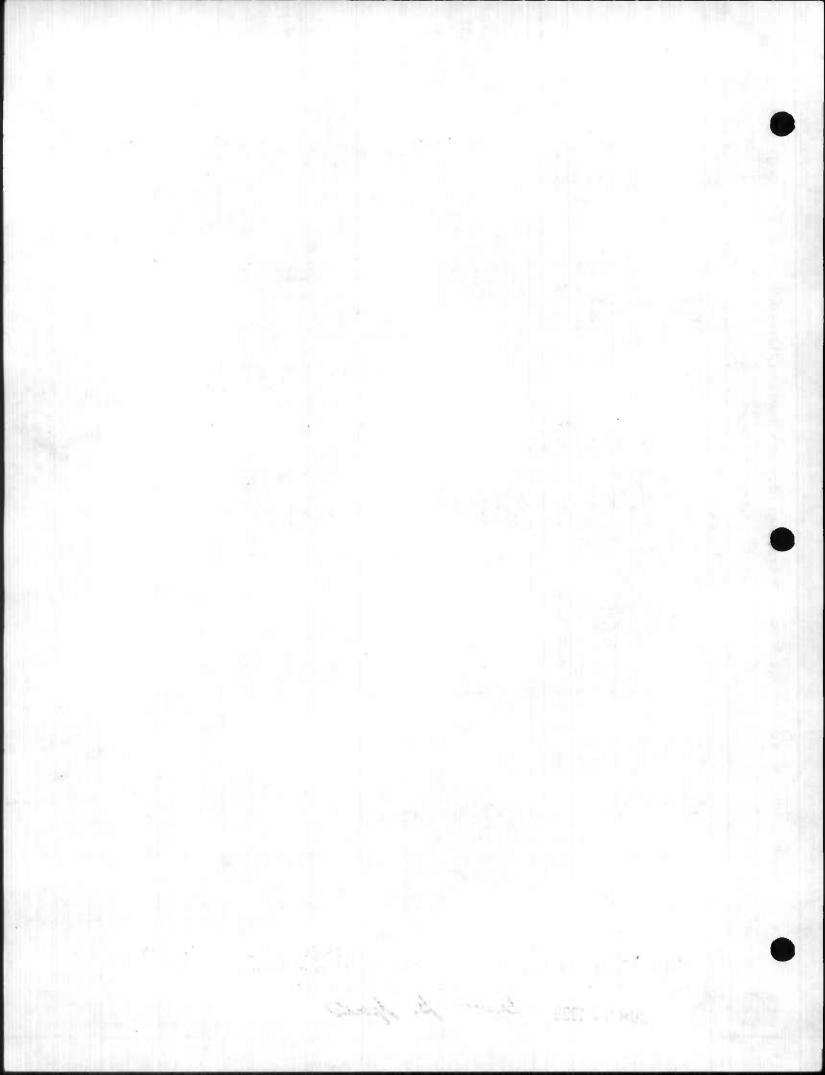


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State of Maryland / Department of Health and Mental Hygiene

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/Medical Examiner	4a Fscility Neme (II	not institution, give	street and number	er)				4b. City, Town, o	or Location of Dea			J.12	A.M.
	Memorial	Hospital	& Medic	al Ce	nter			Cumb	erland		Alleg	any	
Funeral Director	5. Social Security No. 225-16-84	umber 6. S		Age (In yrs	last birtho	Month	er 1 Year s Days		s. 8. Date of B	irth Nay, Year)		ace (State of	or Foreign
	Usual Residence of	Decedent				1			1.01	, , , , ,		72.	
rytan how	10a. State	10b. County			ity, Town o						10	d. Inside C	
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Dire Dire	10a. Street and Nun	nber				10f. 2	ip Code			10g. Citizen of	What Countr	ry?	
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ther death v r hams 23a siner must Funeral	11. Merital Status	37	12. Was Deceder Armed Force	5?	J,S.	Wes Decif Yes, sp	edent of I	Hispanic Origin? an, Mexican, Pue	(Specify Yes or Norto Rican, etc.)	lo- 14. Rad Bla	ce - America ck, White, e		
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should by and Menta marked armstic ev.		. Waters							D. (Her				
S and and and and and and and and and and	19a. Informant's Na									ber, City or Town	, State, Zip (Code)	
C T 24 L		e Waters-	wife	1). Box			ield, W			- 11000	
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parmit. Pages 1 at Department of Hea Important: If them: any injury or other page.	21. Signature of Fur	heral Service Licen	ha	re W		22. Name	and Addre		_	i Funera		ne, P.	Α.
	23a. Part1. Enter the shock, or hear	ne disease, or cémi 1 failure. List on y	ations that cause on each	ed the dea line.	th. Do not	enter the m	ode ot dyi					Approximel Interval Bet Onset and	tween
Physician /Medical	Immediate Cause (I	Finel	Metas	tatio	aden	ocarc	inoms	a to liv	er			week	
Examiner	resulting In death)	'	e. Hetas			sequence o		I CO IIV	CI			WCCK	.0
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* 04		L	d										3.
d for	Part II. Other signifi	cent conditions or	atributing to death	but not re	sulting in th	e underwin	reuse di	ven in Part i	23h Di	d tobacco usa co	ntribute to	the cause	of death?
The law requires that the death certifiate has been signed by the attending page 2 should be detached for use a Completed by Physician/Me	Partii. Other signifi	can conductions of	intributing to death	DUCTION	saking in th	o underlying	Cause gi	VOIT NIT OIL I.		Yaa 2 No			Unknow
or Attending Physician: The law requires the after death. Director: After this certificate has been signe if in by the funeral director, page 2 should be ertification: To Be Completed by									24 W	is an autopsy	24b. Wa	re autopsy	findings
The law require cate has been signed 2 should Completed									per	formed?	ava	ilable prior	to
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29a. Certifier (Check only	DE Certifying Phy	rsician: To the be-	st of my kn	owledge, d	eath occurre	ed at the ti	me, date and pla	ce, and due to th	a cause(s) and m	anner as sta	ated.	(2)
the H the F the F	one)		and menner		z.ion enero				STOO OL LITO LITT				-/
To the com	29b. Signature and	title of certifier	5			2	9c. Licen:	se number		29d. Date sign	ed (Month, D	Day, Year)	
12		B	11				D 233	371		June 25	,	199	19
700	30. Name and addre	ess of person who	ompleted cause o	f death (Ite	m 23a) (Ty	pe, Print)	625 I	Kent Ave	nue	Suite 1			
ms	Dr. Qamar	Zaman, J	ohnson H	eight	s Med				mberland		21502		
		h, Dey, Year)		strar's Sign									

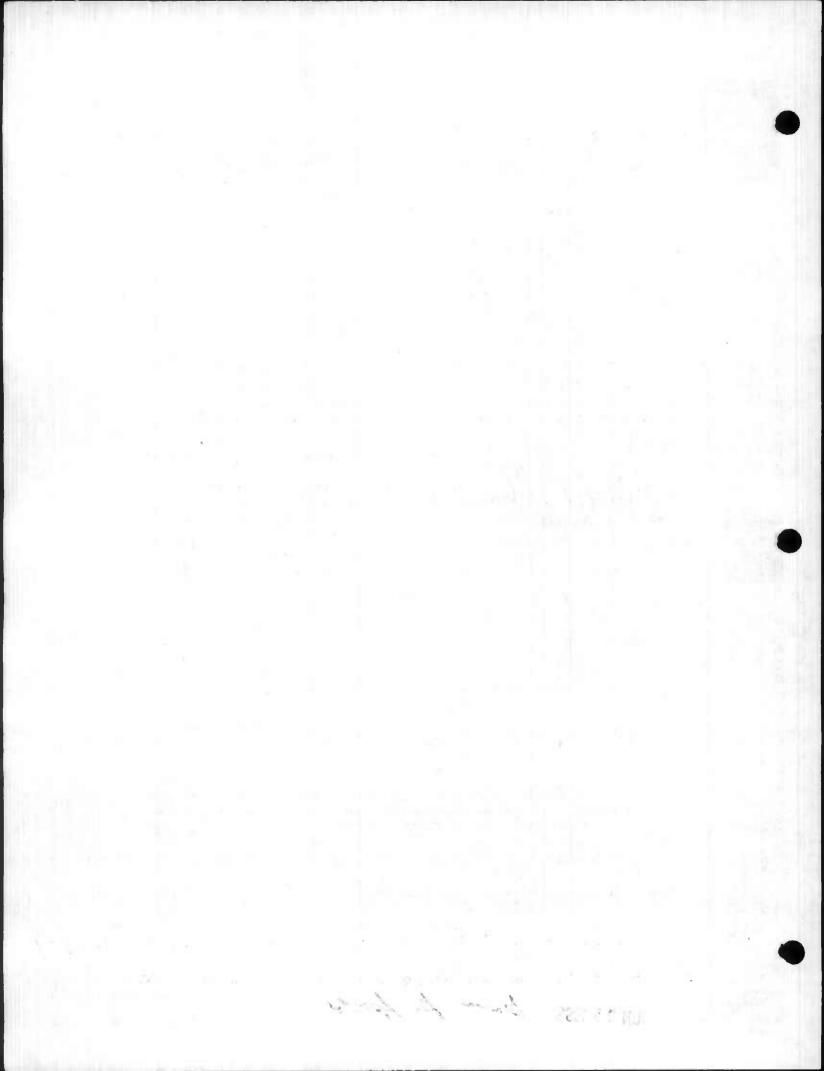
BRUCE WATERS



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State of Maryland / Department of Health and Mental Hygiene 99 2 1851

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	Physic		1. Decedent's Name (First, Midd Anna Maybelle						2. Date of Death June 2	3 ^{Day} 1999	Year	3. Time of Death 1:17 a.m.
þ	/Medi Exami		4a. Fecility Name (If not institution Sacred Heart Ho	on, give street and numbe	ər)			4b. City, Town, or L Cumberlar	ocation of Death	4c. County of	of Deeth	1.1/ d.ill.
Ī	Funeral , Director		5. Social Security Number 220–10–1770	6. Sex 7. 1 M 20 F	Age (In yrs. las	t birthdey) Yrs.	If Under 1 Year Months Days		8. Date of Birth Month, Pay, June 12		-	elace (State or Foreign MD
	Maryland a-f show	tor	Usual Residence of Decedent 10a, State 10b, County MD Alle			Town or Local					1	0d. Inside City Limits 1 X Yes 2 No
	23e or 28	Funeral Director	10e. Street and Number 16 East Railro	ad Street			10f. Zip Code 21539			g. Citizen of W	het Cour	ntry?
020	filed within 72 hours after death with the Maryland Hygiene. hatural', or Items 23e or 28e-f show ont, the Medical Evarring must be notified.	by Fune	11. Maritel Stetus 1 □ Never Married 2 □ Mar 3 🏿 Widowed 4 □ Divorced	If Voe Give	No		Vas Decedent of P Yes, specify Cub ☐ Yes 2 No	dispanic Orlgin? (Sp en, Mexicen, Puerto Specify:	pecify Yes or No- Ricen, etc.)		, Whita,	
15-0	in 72 h	Completed by	(Specify only highe	nt's Education est grade completed)		16a. Deced	ent's Usual Occup kind of work done	pation during most of world)	king	6b. Kind of Bus	siness/Inc	dustry
212	filed withi Hygiene. other than	Comp	Elementary/Sacondary (0-12)	College (1-4o	(5+)	Homem				Home		
and	A ta b	Be	17. Father's Name (First, Middla, James M. Robert	,					a (First, Middle, M	a <i>idan Sum</i> eme)	
ary	should band Mente	J.	19a. Informant's Name/Ralations	ship (Type, Print)				Mary E.	ral Route Number,			
e, M	Health Health em 27 i		Don R. Robertso	on broth				ow Road S			-	
Baltimore, Maryland 21215-0020	ages ant of tt: If it		20a. Method of Disposition 1 Buriel 2 Cremetion 4 Donation 5 Other (S	Specify)	Suns	et Me	ition (Neme of etory or other ple morial P	e) Park	Tuno 251°	oc. Location - C cumberla	,	
Bal	permit. P Departme Importan eny injur		21. Signature Fuherel Service	Licensee Lac	ller		Name and Addre Chhorn—M naconing	ess of Facility CKenzie F	uneral H	ome P.A	۸.	
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List immediata Cause (Final disease or condition			Do not ente	r the mode of dyir	ng, such as cerdiac	or respiratory erre	st,		Approximate Interval Batween Onset and Death
	Examiner	L	resulting in death)	a Acute p	ulmona: Dua to (or a					-	2	days
x 68760,	certificate be executed nding physician end use as the buriel-transit	Physician/Medical Examiner	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in deeth) Last	b. Acute_c	Due to (or as	s a consequ	ence of):				2	days
P.O. Box	death e etter	Physician	Part II. Other significant conditions Coronary artery	one contributing to death	but not resultir	ng in the un	derlying ceuse giv	en in Part I.	23b. Did tob	1/	ributs to	the cause of death?
Division of Vital Records,	been should	Completed by	Cerebral aneury						24a. Was an	autopsy ed?	cor	era autopsy findings allable prior to appletion of ceuse death?
E Re	Physician: The law this certificate has b rai director, page 2 s	Com							1 🗆 Yes	2 No		Yes No
Vita	Physician: r this certific rai director,	Be	25. Was case referred to medica examiner?	Hospital: 1			Oth	or:	h (Check only ona			
10	g Phys er this eral di	n: To	1 ☐ Yas 2 No 27. Manner of Death	28a. Date of In	jury 28	Outpatient b. Time of	3□ DOA Oth	+ Li Nursing Ho	ome 5 Rasider 28d. Describe how)
Sior	Attending r death.	catio	1 Natural 5 Pendir 2 Accident Investig	gation	юу төөт)	Injury		Yes 2 □ No	150-25-25			
D V	al or Attend s after death il Director: /	Certification:	4 Homicida determ	ined 28a. Place of fi	njury - At home etc. <i>(Specify)</i>	, farm, stre	at, factory, office		28f. Location (Str. City or Town,		r or Rura	Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) Certifyin 2 Medical	ng Physician: To the bes Examiner: On the basis and manner s	of axamination	dge, death of and/or inve	occurred at the tin estigation, in my o	ne, date end place, pinion, daath occur	and due to tha cer red at the time, dat	use(s) and manu e and place, an	ner as stand due to	ated. the ceuse(s)
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	nes		30. Name and address of person Chang Hyun Oh,					04, Fros	tburg.Md	. 21532		
Ī	Sta Registr	-	31. Date filed (Month, Day, Year)	32 Regis	trar's Signature	-	foods					



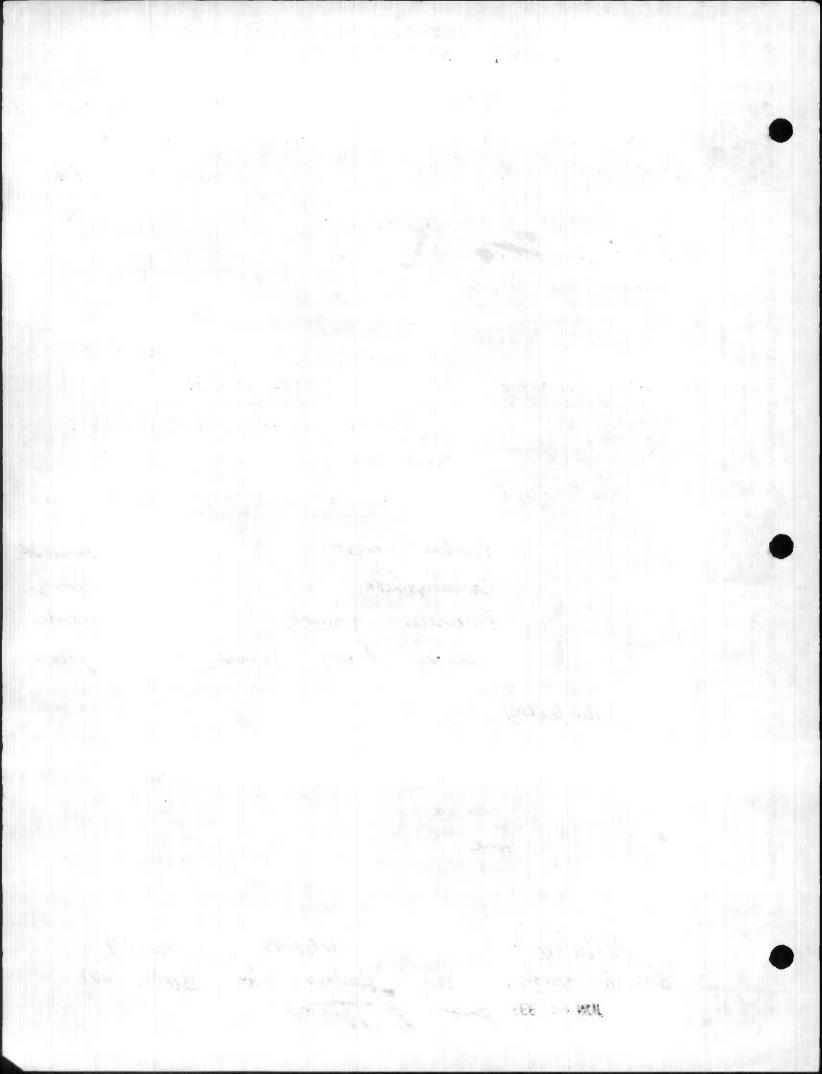
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** OSCAR SCOTT WILSON 28 1999 20:29 06 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SACRED HEART HOSPITAL CUMBERLAND If Under 24 Hrs. ALLEGANY If Under 1 Year 8. Date of Birth (Month, Day, JUNE 15 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MARYLAND **Funeral** Days Year) 1905 Hours 1 M 2□ F Months Min. 214-05-4325 94 Yrs. Director Usuel Residence of Decedent e 28a-f show a notified at 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director MARYLAND ALLEGANY CUMBERLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð 13819 VALLEY ROAD N.E. 21502 U.S.A. Berns 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 1 No if Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 72 hours after 1 ☐ Never Merried 2 ☐ Merried "natural", or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than " College (1-4or 5+) Elementary/Secondary (0-12) 8 HARDWARE STORE/CLERK SALESPERSON/CLERK 17. Father's Nema (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be 10 EMORY WILSON DORLESKIA ATHEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2.
Department of Health an Irroportant: if then 27 is many injury or other DEIRDRE BOONE DAUGHTER 3831 CARRIAGE HOUSE DRIVE CAMP HILL PA. 17011 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 ☑Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) SUNSET CEMETERY JULY 1 1999 CUMBERLAND MARYLAND 22. Neme and Address of Facility MERRITT-ADAMS FUNERAL HOME ale ox 404 DECATUR STREET CUMBERLAND MARYLAND 23a. Partl. Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Deeth **Physician** Immediate Cause (Finel diseese or condition resulting in death) /Medical year. discase Examiner Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury Due to (or es e consequence of): 68760 Physician/Medical that initiated evants resulting in death) Last Due to (or as a consequence of): Box (23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown nen Division of Vital Records. Š The law requires 24b. Wara autopsy findings eveilable prior to completion of cause of death? 24a. Was en autopsy performed? Completed Deen certificate has page 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Physicien: 8 25. Was casa referred to medical 26. Place of Deeth (Check only one) examiner? Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) To 1 Yes 2 No this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Panding invastigation Injury 1 Natural 1 Yes 2 No 2 Accidant 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner steted. 29a. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 033280 June, 30 1999 mu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 DR SUNIL K. GUPTA 625 KENT AVE. CUMBERLAND MARYLAND 31. Deta tiled (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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/Medical Examiner	4a Facility Nama (If not institution, giva				4b. City, Town, or Lo		4c. County	-4-4	01))
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician naxine Anderson /Medical 4b City, Town, or Location of Death Examiner Dita If Under 24 Hrs. 8. Date of Birth (Month, Day, If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 9 Birthplace (State or Foreign **Funeral** Days Months Hours 1 M 2 F Director Usual Residence of Decede with the Maryland 10d. Inside City Limits 10a, State Town or Location r than "naturel", or forms 23a or 28a-f ahow the Medical Examiner, must be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 223 Funeral deeth 12. Was Decedent Eyer in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Rlack. White, etc. pernit. Pages 1 and 2 should be filed within 72 hours efter Department of Hasilth and Mentel Hygiens. Important: if Itam 27 is marked other than "naturel", or the Important: or other traumetic avent, the Medical Exemple Page. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 1 No BLACK 1□ Yes 2B No altimore, Maryland 21215-0020 Specify: P 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working
/ /ife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ondary (0-12) College (1-4or 5+) er's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) 8 Informant's Name/Relationship (Type, Print) 20b. Plece of Disposition (Name of cemetery, cremetory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State cremetory or other pl 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee ton 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not shook, or heart feiture. List only one cause on each line. the mode of dying, such es cardiac or respiratory arrest Approximete fnterval Between Onset and Death Physician /Medical 15 min Immediate Cause (Final disease or condition resulting in death) Examiner Examiner za. attending physician and for use as the burlal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): bete Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions combibuting to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown bengla be de à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vital director, 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient 11: 28a. Date of fnjury (Month, Day Year) To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director; After thi completely filled in by the funeral funeral 28d. Describe how injury occurred anner of Death 28c. tnjury at Work? 28b. Time of 5 Pending investigation 1 Natural 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

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Registrar **DHMH 16 Rev 6/95**

State

DAVID

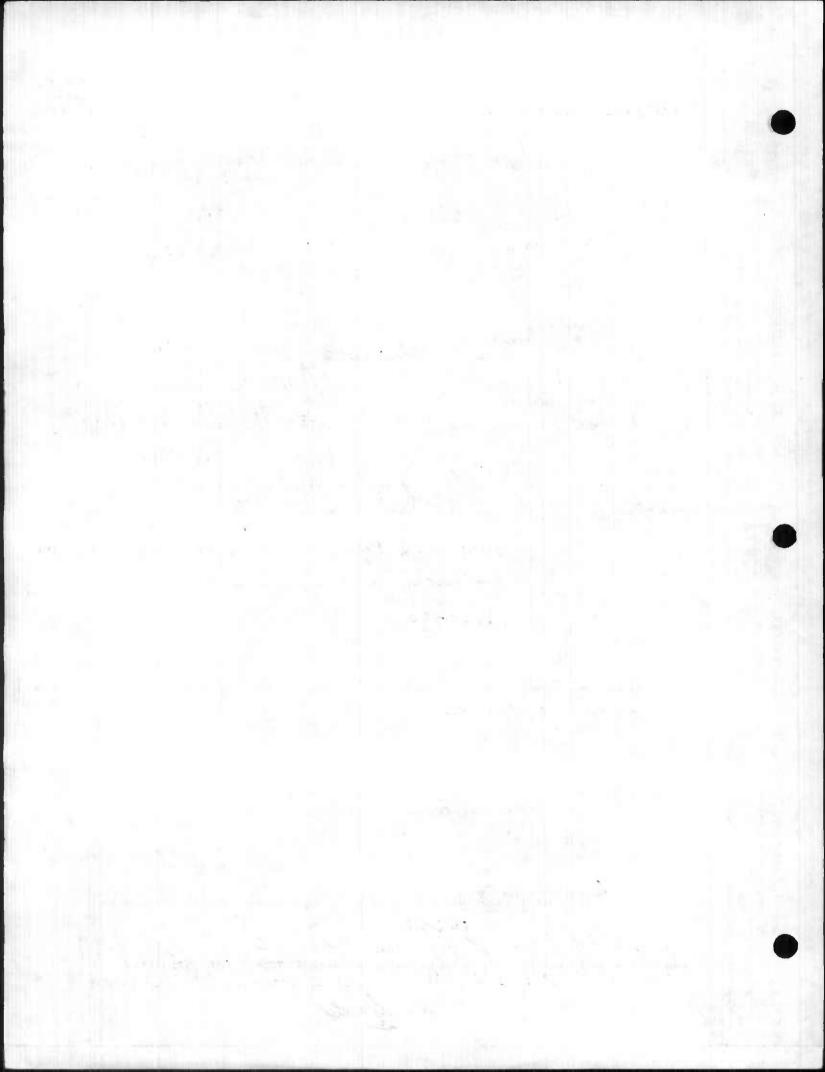
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se of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Dev Month **Physician** LYNeTTE 1999 Jul 11 1221 /Medical cility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Arunde OleN urnie If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys 1 M 2 XF Hours Director 214-42-1958 Aug 29, 1941 Maryland Usuel Residence of Decedent death with the Meryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ehow. r than "naturel", or items 23a or 28a-f ehor the Modical Examiner must be nottled at 1 Yes 2 No Director Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 2104 Eastway 21060 Funeral 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian 12. Wes Decedent Ever in U.S. 11. Maritel Status Armed Forces?
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If Yes, Give Black, White, etc. flied within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify p 3 Widowed 4 Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary 12 n/a Law 7 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 end 2 should be nant of Health and Mentel Elizabeth Katherine Boehm John Henry Koch Austin 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Health em 27 i 10 Sandspring Court, Cockeysville, MD 21030 Jane A. Scholtes/Sister other or othe 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removel from State 7/15/99 permit. Page Department c Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Grdns 21. Signature of Funeral Service License 22. Name and Address of Fecility emmon Funeral Home 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory erresponds to the cause of Timonium, MD Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Examiner that the death certificete be executed physicien and the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical Due to (or as e consequence of) 50 for use as signed by the a d be dateched f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably Wunknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24e. Wes an autopsy performed? ils certificate her 1 Yes 2 10 No 1 Yes 2 No Attending Physician: Be 25. Was case referred to medical 26. Placa of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ inpatient 2 ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after deat Director: 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) A 24 hou.

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filled in by 4 - Homicide 5 Hospitai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, and due to the cause(s) and manner as stated. Medical To the Fune (Check only one) 2. Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. To the Within 2 29b. Signature and title of cartifier 29c. License number 29d. Dete signed (Month, Day, Year) Deputy lefed cause of deeth (item 23a) (Type, Print)

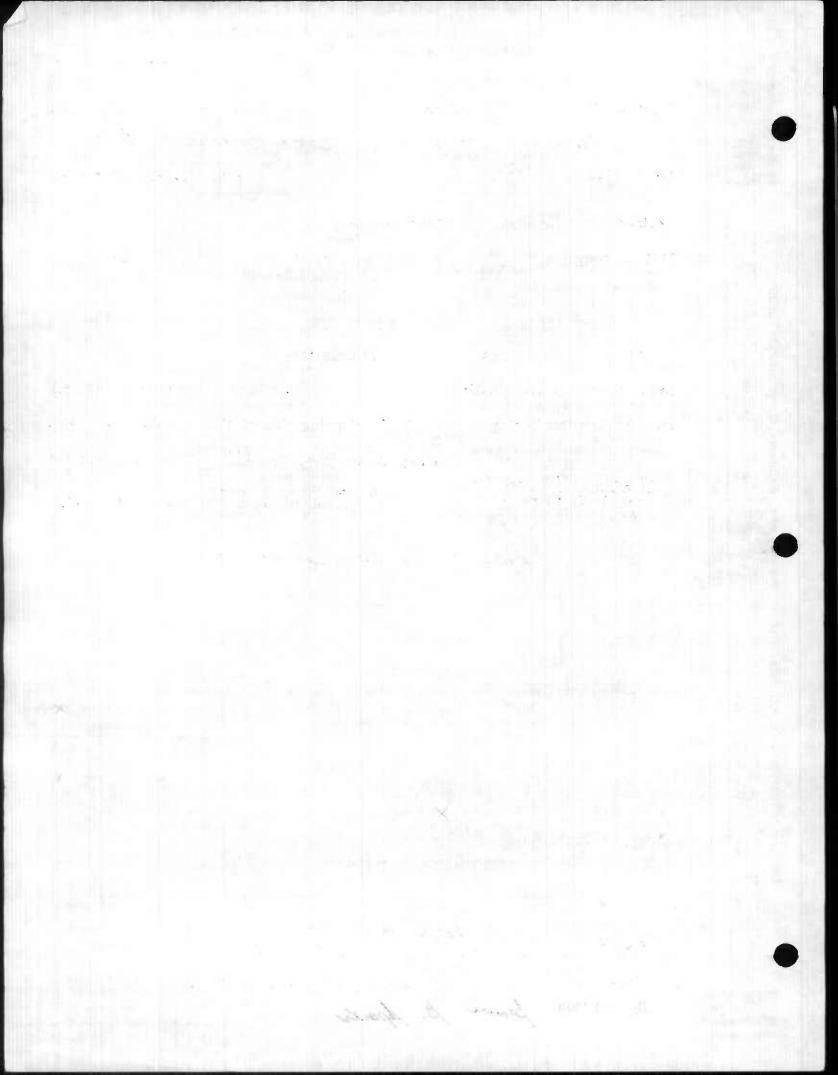
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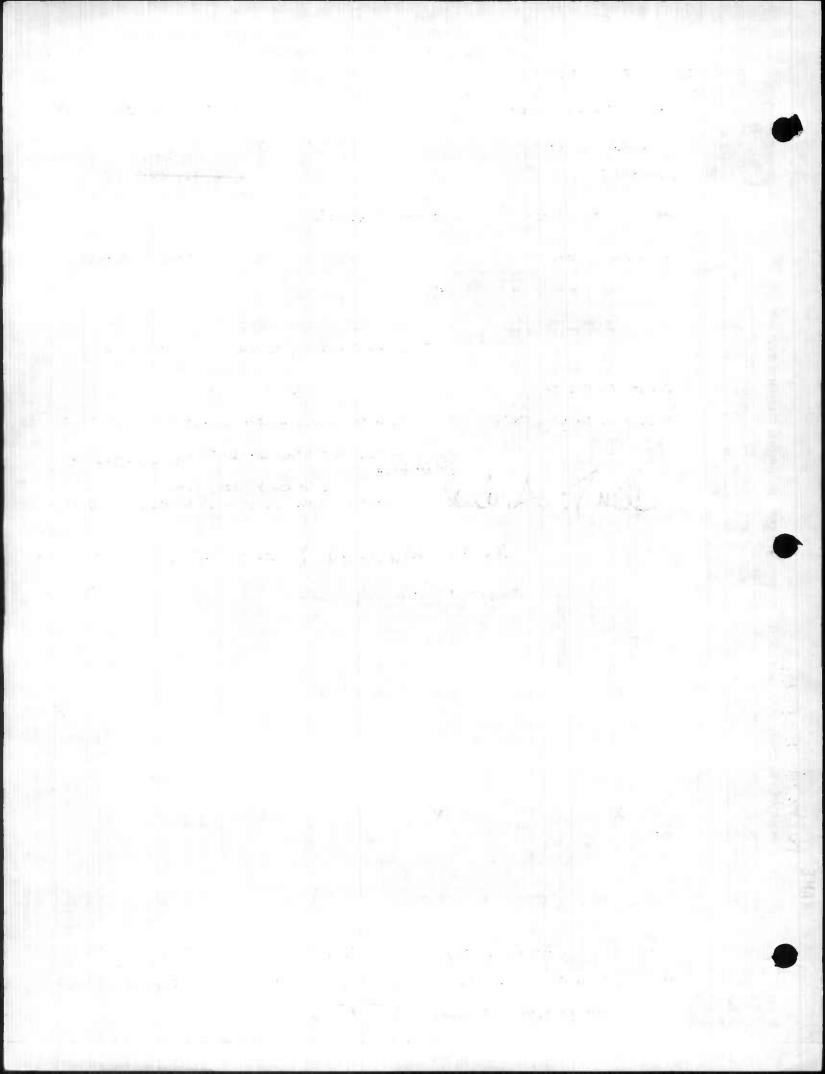
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death Amended Item#8 perFH G773 7/15/99 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Year **Physician** Richard Howard Besece 11 1999 JULY 1609 /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner ST AGNES HOSPITAL 8. Date of Birth 5-12+32 9. Birthplace (State or Foreign (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Min Months Deys Hours 11XM 2□ F Yrs 278-28-3070 Director 67 Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylen Department of Heelth end Mental Hygiene.
Important: If item 27 is marked other then "netural", or itema 23a or 28a-f ahow any hjury or other treumetic event, the Modical Exacting from the Incities and once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Baltimore Highlands 1 Yes 2€ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2714 Daisy Ave. 21227 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritel Status Yes 2 No No Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☑ Merried 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Shipping/Receiving Clerk Production 12 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Joseph G. Besece Agnes Manley 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Vivian M. Besece, Wife 2714 Daisy Ave., Baltimore Highlands, MD 21227 altimore, 20b. Place of Disposition (Neme of cemetery, cremetery or other place)
Maryland Veterans Cem. 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 □ Cremetion 3 □ Removel from State 7-15-99 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD of Funera 22. Name and Address of Fecility Ambrose Funeral Home 2719 Hammonds Ferry Rd., Lansdowne, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical Inforction Myocardial Examiner Due to (or as a consequence of): Examiner DELTENSIAD physician and s the buriel-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Sece. P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 98 use 23h. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en autopsy performed? Completed page 2 s AME RIChard certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28d. Describe how Injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide filled in by 4 ☐ Homicide 0 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as steted. edicai To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signature end title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saint Agnes Healthcare Baltimore Michae Silverman MD 32. Registrar's Signeture 31. Date filed (Month, Dey, Year)" State JUL 1 3 1999

DHMH 16 Rsv 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

CIII	• •			
Margaret Parsons Belcher	State of Maryland	I / Department of Health and Menta	al Hygiene	2185
MEND ITEM: #5 PER INFORMANT G773	7-27-99 WR.	Certificate of Death	Pag No	4100

	1.	Decedent's Ne	me (First, Middl	la, Last)								2. Data of Dea			3. Time of Death
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		sual Residence	of Decedent 10b. County	,	,	100	. City, Town	or Location						100	d. Inside City Limits
ò		MD		V/A				TIMORE	3						1⊠Yas 2□No
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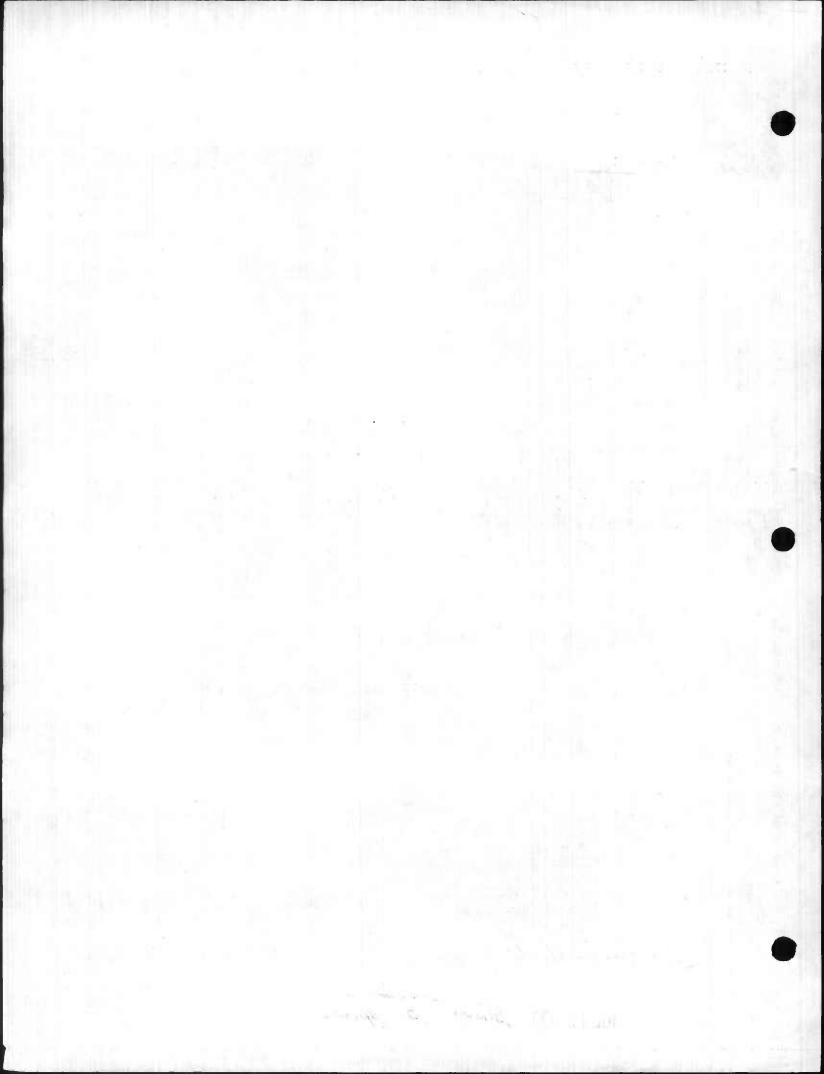
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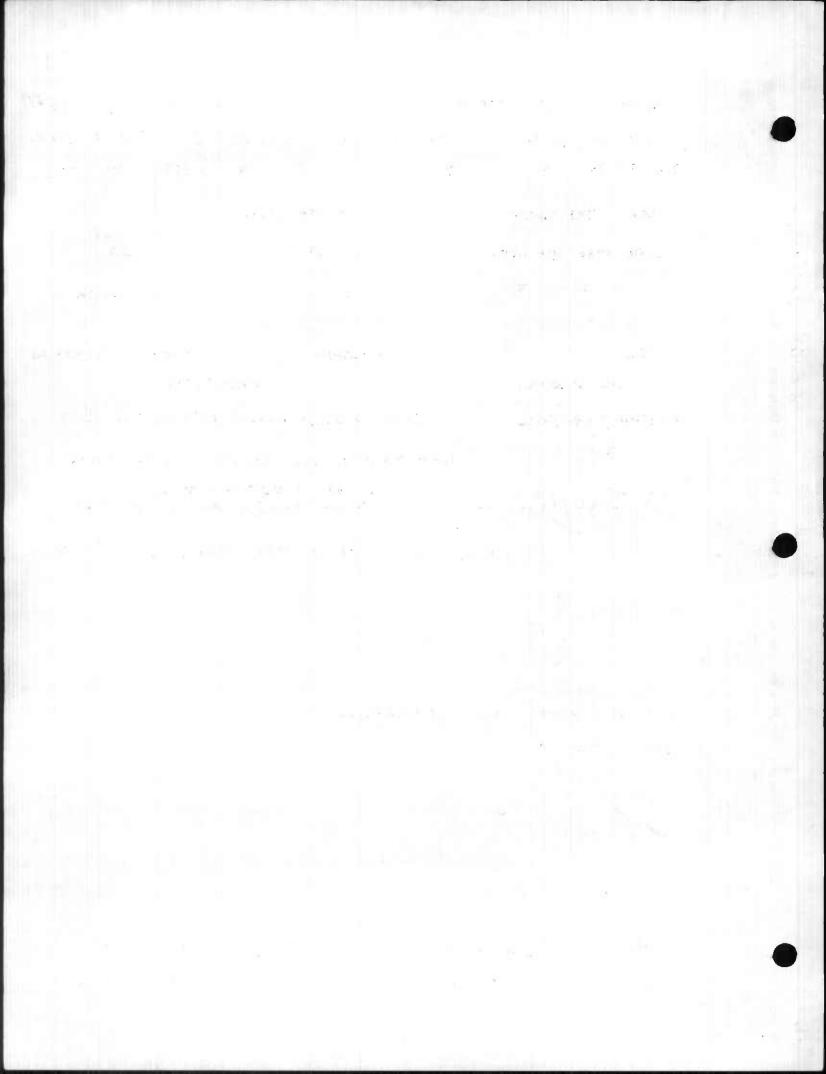
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dete of Death 3. Time of Death July **Physician** Day 199 Year 12; 11:25 AM Annette Marian Baxter /Medical 4b. City, Town, or Location of Death Cockeys ville 4a. Facility Neme (if not institution, giva street and number) 4c, County of Death Baltimore Examiner Maryland Masonic Homes 7. Aga (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 5. Social Sacurity Number 2 1 4 - 3 0 - 3 2 4 3 6. Sax 9. Birthplaca (Stata or Foreign **Funeral** 10 M 20 F Days Hours Maryland 83 Yrs. Director Usual Rasidance of Dacadant Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. insida City Limits tem 27 is marked other than "natural", or items 23a or 28s-f show other traumatic event, the Medical Examinar roust be notified at 1 Yas 2 No Director Baltimore Cockeysville the 10f. Zip Coda 10e. Street and Number 10g. Citizen of What Country? 21030 300 International Cir. USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Giva Yaar or Datas: Was Decedent of Hispenic Origin? (Specify Yas or Notif Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indien, Black, White, atc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental hygiene. Important: If Item 27 is marked other than "natural", or ther any injury or other traumatic event, the Mexical Exercises. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2X No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Collaga (1-4or 5+) N/A Elementary/Secondary (0-12) Own Home Homemaker 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) John William Norris Edna May Bull 19a. Informant's Name/Raletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) P.O. Box 344 Jarrettsville, MD 21084 Henry C. Baxter/Son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel from Stete 20b. Place of Disposition (Nama of cematary, crematory or other plece) July 14, 20c. Location - City or Town, Stata 1999 4 Donation 5 Other (See 1) Parkville, MD Parkwood Cemetery 22. Nama and Address of Facility
Lemmon Funeral Home of Dulaney Valley, 21. Signature of Fee 10 W. Padonia Road Timonium, MD 21093 Michael Flagle 23a. PertT. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. intarval Between Onset and Death **Physician** /Medical Immediata Causa (Finel disaasa or condition rasulting in daath) Examiner feart fáilure **bunial-transit** Sequantielly list conditions, if eny, laading to immadiata causa. Entar Undarlying Cause (Disaesa or Injury that initiated events rasulting in death) Last and Box 68760. attending physician for use as the buna Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 4 Unknown 1 Yes 2 No 3 Probably þ 24b. Wara autopsy findings available prior to completion of cause of death? should should 24a. Was an autopsy performed? Completed page 2 1 Yas 280 No 1 Yas 2 No cartificate Hospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this cartifical letely filled in by the funeral director, I 25. Was casa rafarred to medical Be 26. Placa of Death (Check only ona) axaminer? 1 ☐ Yas 2 ☑ No Other: 4 Nursing Home 5 Rasidance 8 Other (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 1 Natural 5 Pending Invastigation 1 ☐ Yas 2 ☐ No 2 Accident 3 Sulcida 6 Could not be dataminad Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 4 Homicida 29a. Certifier 1 🗹 Certifying Physician: To tha best of my knowledga, daath occurred at the time, dete and place, and dua to the causa(s) and mannar as stated. Medical 2 Medical Examinar: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. To the Within 2
To the Complete 29b. Signatura and till of cartifian 29c. License number 29d. Data signed (Month, Day, Year) 12 020649 towell

6800 York Road Baltimore, MD 21212

30. Namé and addrass of person who complated causa of death (itam 23a) (Type, Print)

32 Registrar's Signetura

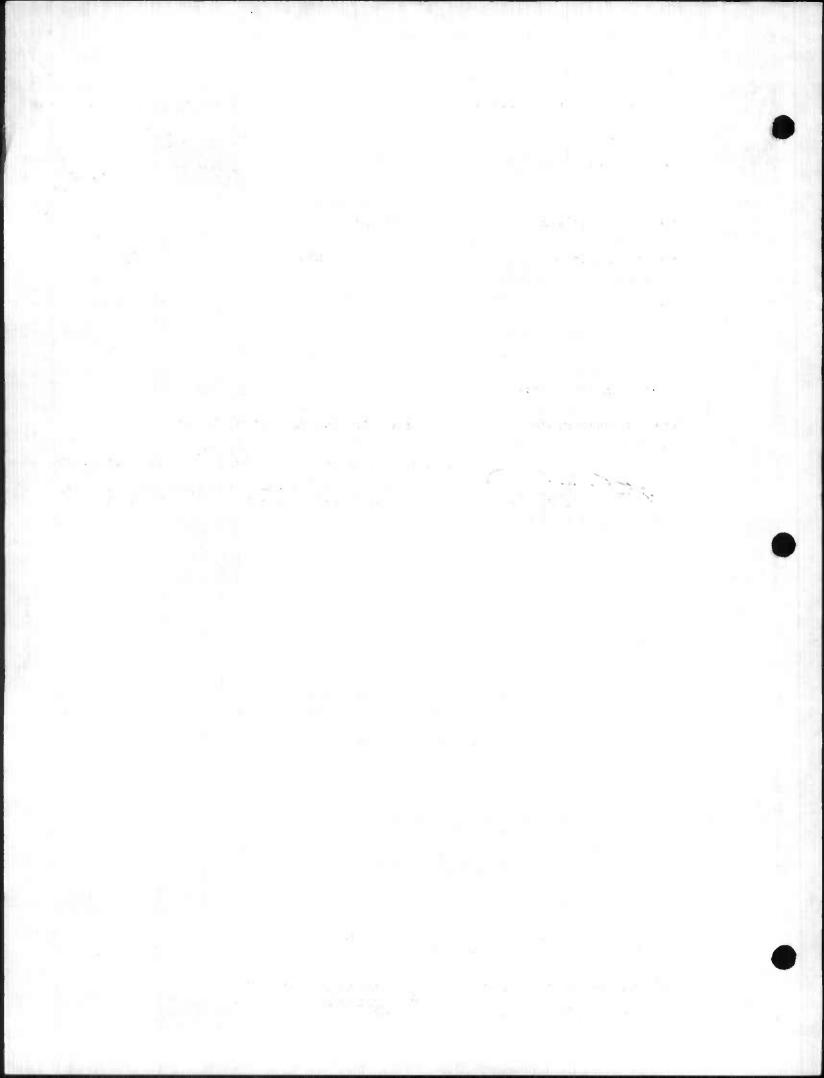
John W. Bowie, M.D.

31. Data filed (Month, Day, Year)

JUL 1 3 1999

Q.F.

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** Month July 8, Lillian Chapman Brooks 11:30AM /Medicai 4a. Facility Name (If not institution, give straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of Gilcrest Towson Baltimore Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 13, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** 1 □ M 2 🔀 F 89 Yrs 577-16- 7937 1910 Virginia Director Usual Residence of Decedent a or 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits MD Howard Columbia 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? frems 23a 21044 U.S.A. 5076 Stoneboat Row Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American indian, Black, White, atc. "natural", or item 1 Never Married 2 Married Black 1 ☐ Yes 2 ☐ No Specify. by 3 → Widowed 4 Divorcad Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highast grade completed) than . Elementary/Secondary (0-12) College (1-4or 5+) i 2 should be filed with n and Mental Hygiene. F.H.A. Clerk marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Catherine Chapman Middleton Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5076 Stoneboat Row, Columbia, Maryland 21044 Health Item 27 (Grandson) Melvin Evans other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 6 Important: If It any injury or c 1 28 Burlal 2 Cremation 3 Removal from State Meadowridge Memorial Park 7/10/99 Elkridge, Maryland ent 4 Donation 5 Other (Specify)

21 Signature of Funda Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. hum 5555 Twin Knolls Road, Columbia, Maryland 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onsat and Death **Physician** . CANCER METMINTIC (UNKNOWN PRIMARY) Immediate Cause (Final disease or condition resulting in death) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown MASSETES MELLITUS by Records. 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? MUM FISHLYTION 1 Yes 2 No Division of Vital Be 25. Was case referred to medical examiner?
1 ☐ Yes 217 No 26. Place of Death (Check only one) Hospital: 1 inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Lother (Specify) HO SPICE Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after deat Director: Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide • Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. To the Hos within 24 ho To the Func (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, to my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and title of cartifier 29c. Licansa number 29d. Date signed (Month, Day, Year) se of death (Item 23a) (Type, Print) MD 21204 BATIMORE Grama N CHARLES State

DHMH 16 Rav 6/95

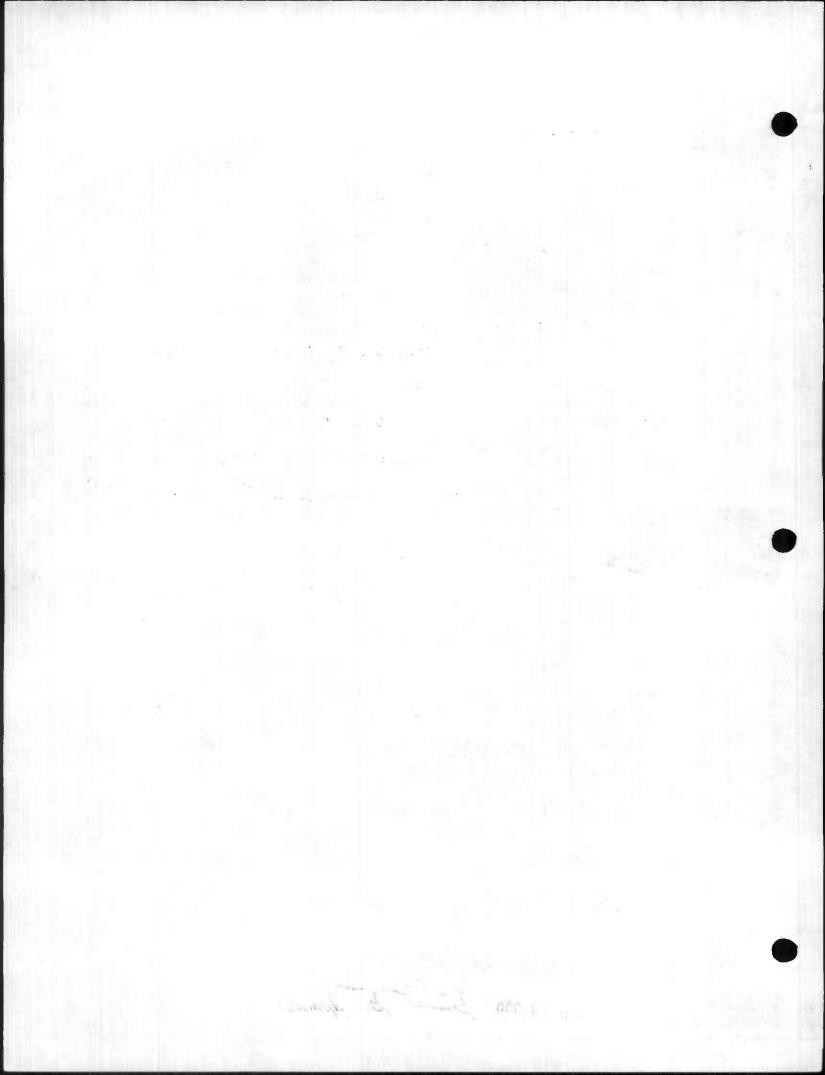
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State of Maryland / Department of Health and Mental Hygiene 99 21861

			(Certificate d	of Death		Reg. No.	2100	1
Physician	Decedent's Neme (First, Middle, Li IRVING			BE	RMAN	2. Dete of Dec Month	Day	Yeer 3. Tima of D	Deeth
/Medical	An English Name (Mant institution of					or Location of Death		999 3:16 of Death	· pm
Examiner	SINAI H	OSPITAL			BALTIM	ORE	N/A		
Funeral Director		Sex 7. Age ((In yrs. last birtho	Months Dr		Hrs. 8. Date of Birt Min. (Month, Da)	1918	9. Birthplace (State or I Country) MD	Foreign
Mand Hand	10a. Stete 10b. County	1	IOc. City, Town o	r Location				10d. Inside City	Limits
Many Hah	MD BALTIMO	RE	BALTIMO	RE				1 ☐ Yes 2	20 No
death with the Maryland ma 23a or 28a-f ahow count to notified at	10e. Street and Number 2504 LIGHTFOOT	DRIVE		10f. Zip Coo	21209		10g. Citizen of W		
Urs after urs after alf, or its	3 ₩idowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		13. Was Decedent If Yes, specify (Cuban, Mexican, P	? (Specify Yas or No- uerto Rican, etc.)		e - American Indian, k, White, etc.	
72 ho	15. Decedent's E (Specify only highest gr		10	ecedent's Usual Oc live kind of work do	ne during most of	working	16b. Kind of Bu	siness/Industry	
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and 2 be filed v ital Hygie d other avent, tt	17. Fether's Name (First, Middle, Las		GEN	ERAL CONT	1	Neme (First, Middle,			
ylan bould be Mental arked o	MILTON		BEF	RMAN	IDA			BERMAN	N
E SEE	19a. Informent's Neme/Relationship	(Type, Print)	19b. N	lailing Address (St	eet and Number o	Rural Route Number	er, City or Town,	State, Zip Code)	
M P P P P P P P P P P P P P P P P P P P	HOWARD BERMAN /	SON	250	04 LIGHTF	OOT DRIVI	E - BALTIM	IORE, MD	21209	
or of H	20a. Method of Disposition 1 🕉 Burial 2 □ Cremetion 3 [4 □ Donetion 5 □ Other (Speci	Removal from State	cemetery,	isposition (Name of cremetory or other ON CHIZUK	place)	7/11/99		ORE, MD	
Baltim Permit. Pag Department Important: It any injury o pose.	21. Signeture of Funeral Service Lice	nsee		22. Name and Ad 8900 REI				ROS., INC. LE, MD 2120)8
Physician /Medical Examiner	23a. Pert1. Enter the disease, or con shock, or heart feilure. List only immediate Cause (Final disease or condition resulting in death)	one cause on each line.		/	,	diac or respiretory and the second se	rest,	Approximate Interval Betwe Onset and De	
. BOX 68/60, death certificate be axecuted e attending physician and id for use as the burial-transit	Cause (Disease or Injury thet initieted events resulting in death) Last	U	ue to (or as a con		heart a	liteau.			
at the death ce dby the attendi etached for use	Part II. Other significant conditions				given in Part I.	23b. Dld 1	obacco usa cor	ntributa to the causa of	death?
CONGS, P.O. requires that the de been signed by the should be detached	Moderna	aprofic Cancer	Gher	ryom.		10'	Yaa 200 No	3 Probably 4 U	Inknown
II HECONGS, P. The law requires that page 2 should be dear Completed by PI	10 state	Cancer	,			24a. Wes perio	an autopsy med?	24b. Were autopsy tin available prior to completion of car of death?	
The law cate has page 2						101	(es 2)2 No	1 ☐ Yes 2 ☐ N	No.
OT VITAL Physician: The This certificate and director, page 1: To Be Co		Hospitel:	1		Other	Deeth (Check only o			
T dis p		1 LI Inpatient			4 LI Nursir	ng Home 5 Resid	lence 6 Other		
ISION OT Trending Physics: Tor: After this The funeral di Cation: To	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	(ear) Inju		njuryat Work? 1 ☐ Yes 2 ☐ No	200. 00001100 1	on injury coodii		
2.95 -	3 Suicide 6 Could not be determined	00 Diago of Injury	/ - At home, farm (Specify)	, street, factory, off	ice	28f. Location (S City or Tox		er or Rural Route Numbe	er,
To the Hospital or / within 24 hours after To the Funeral Dire completaly filled in E		nysician: To the best of a miner: On the basis of ea and manner state	camination and/o	eath occurred at the investigation, in r	e time, date and p ny opinion, deeth o	lace, end due to the occurred et the time,	ceuse(s) and me dete end place, a	nner as stated. and dua to the cause(s)	
or with the state of the state		4	1/1	29c. Lig	ense number	379	29d. Dete signed	(Month, Day, Year)	
Ó	30. Name and address of person who	VREA, 77		De, Print)	Conro	nd; B	altimo.	11, 10 2/2	of
State	31. Date filed (Month, Day, Year)	1 3 1000 degistrar	Signature	B. A	park	/			



Examiner The law requires that the death certificate be executed Box 68760, 0 Division of Vital Records, P. Hospital 24 hours a

Physician/Medical the signed by the atte þ Completed al or Attending Physician: The safter death.

Is after death.

In Director: After this certificated in by the funeral director, pi Be 2 Certification: filled in by Medical

Physician

/Medicai

Examiner

Funerai

Director

28a-f show

items 23a

Directo

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Completed

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traumatic event, the Medical Examiner must be notified at

the Marylend

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permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health end Mental Hygiene. Important: if frem 27 in marked other the any Injury or other trainments.

Physician /Medical

and

attending physician

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certificate has

24 hours a

To the I

State Registrar

rongelowe 31. Date filed (Month, Day, Year) 13 JUL

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signeture end title of certifier

and manner stated.

29d. Dete signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

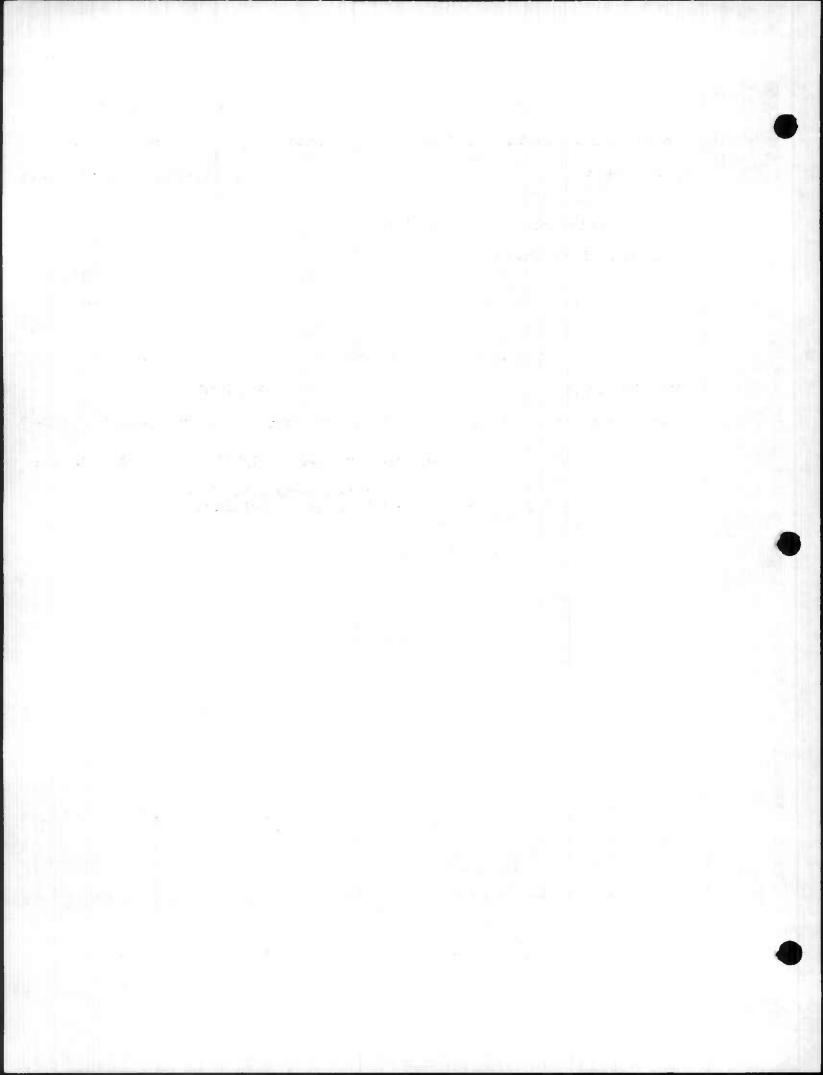
32. Registrar's Signature

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Ba Hower, MD 21236

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

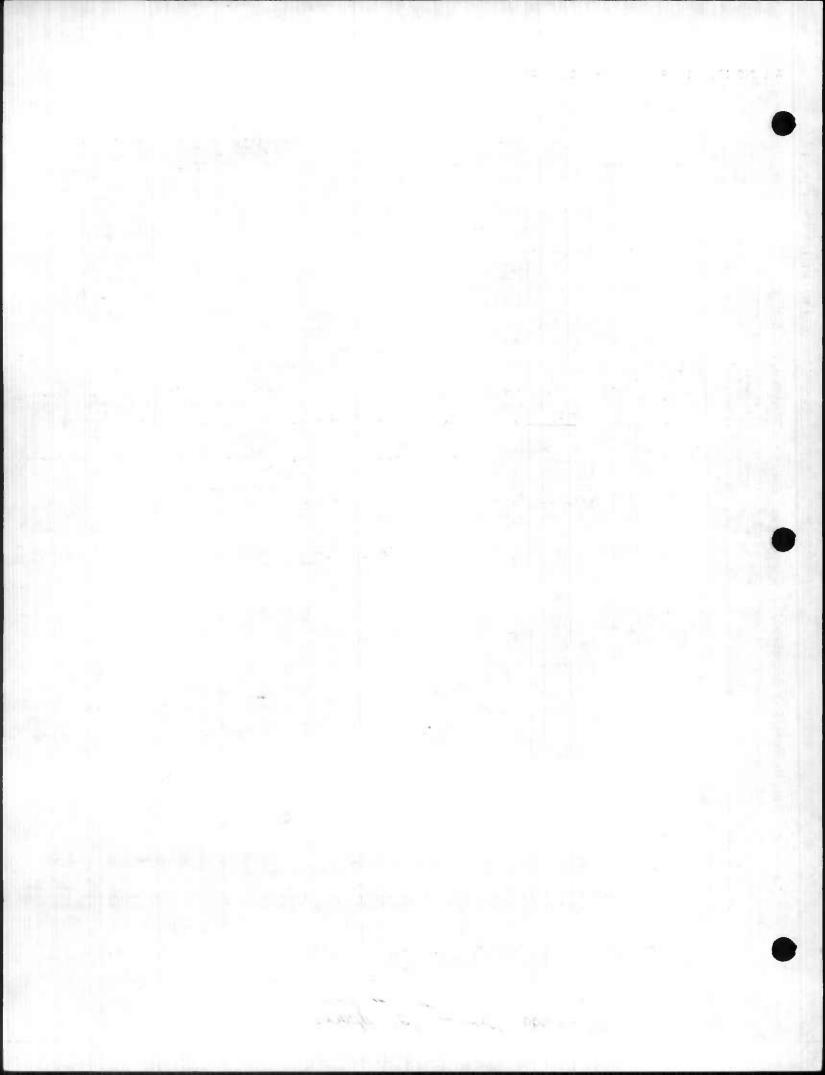
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

AME	NDED ITEM A		partment of Health and Mertificate of Death	lental Hygiene 99	21863
AME	Physician	1. Decedent's Name (First, Middle, Last)	SETTES	2. Dete of Death Month Day Yea	3. Time of Death
Š	/Medical Examiner	4a Facility Name (tf not institution, give street and number)	4b. City, Town, or Lo	JUI 11 1996 position of Death 4c. County of De	
	Funeral Director	Oak Crest Care Center 5. Social Security Number 6. Sex 135-22-1372 1 M 2 F 83 Yrs	Months Days Hours Min.	B. Date of Birth (Month, Day, Year) 9. B	imore Birthplace (State or Foreign Country) ew Jersey
	yland	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or			10d. Inside City Limits
	or 28a-f at the morning	*	ville		1 ☐ Yes 2 ☒ No
	Mith E	10e. Street and Number 8832 Walther Blvd.	10f. Zip Code 21234	U_S_A	
20	72 hours after death with the Maryland setural; or theme 23a or 28e-f show seel Earning mart be nothed a sted by Funeral Director		3. Wes Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:		merican Indien,
21215-0020	ed within 72 houn ygiene. nor than "natural", n, m than eal th.	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+)	ocedent's Usual Occupation we kind of work done during most of work e. DO NOT use retired)		
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Mar	D = 7	DEPEW	ailing Address (Street and Number or Run Windy Hill Road, G		
ore,	~ £ 5 5	20a. Method of Disposition 20b. Place of Di	sposition (Name of crematory or other place)	Date 20c. Location · City	
Baltimore,	Page 1			-14-99 Piscatawa	y, New Jersey
Bal	Departmen Departmen Important: eny Injury : Rites	victade 5. 18 word, 81.	22. Name and Address of Facility Ruck Towson Funeral 1050 York Road, Tow	rson, Md. 21204	
	Shusisian	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart feilure. List only one cause on each line.	enter the mode of dying, such es cardiac	or respiratory errest,	Approximate Interval Between Onset and Daeth
2	Physician /Medical	Immediate Cause (Final disease or condition DEMENTIA	multi-infar	t	years.
	Examiner	resulting in death) Due to (or as a con			0
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	death ed for sicia	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Pert I.	23b. Did tobacco use contribu	uts to the cause of death?
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u of	g Phy ter this neral d	27. Manner of Death 1 Deletural 5 Pending (Month, Day Year) 28b. Time (Month, Day Year)	e of 28c. Injury at	me 5 Residence 6 Other (S) 28d. Describe how injury occurred	респу)
Division	To the Hospital or Attending Physicien: The is within 24 hours after death. To the Funeral Director: After this cartificate he completely filled in by the funeral director, pages. Medical Certification: To Be Com	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, building, etc. (Specify)	M 1 Yes 2 No	28f. Location (Street and Number or City or Town, Stete)	Rural Route Number,
	To the Hospital within 24 hours for the Funeral completely filled Medical Co	29a. Certifier (Check only one) 10 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the best of examination and/or and manner stated.	r investigation, in my opinion, deeth occur	ed at the time, date and place, and d	lue to the cause(s)
	within Z	29b. Signature and title of certifier	29c. License number	29d. Dete signed (Mo	onth, Dey, Year)
		Kendale Kraulkneur	D 25643	7/1/9	9.
		30. Name and address of person who completed cause of death (Item 23a) (Tyn LR Faulkner/ 8800 Walther (Bud/ Baltimore	MD 21234	
	State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	. Sparks	29d. Dete signed (Mo 7/U/9 MD 21234	

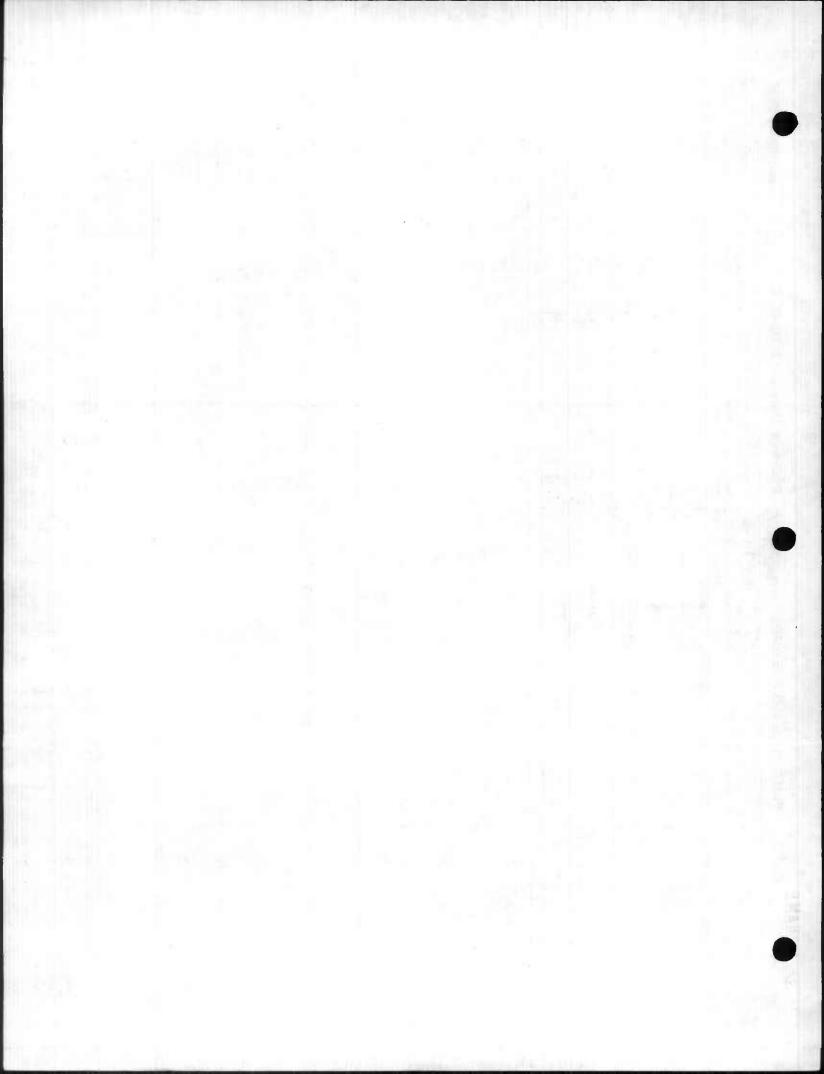
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State of Maryland / Department of Health and Mental Hygiene Q 864 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month Year **Physician** MARGIE COLE 7:20 A.N 10 1993 JUL /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL ST. AGNES BALLIMONE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (tn yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1□ M 201 89 Yrs. 218-18-8112 Director OCT 8 1909 MARYLAND Usual Residence of Decedent Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be nothing at YYes 2 No Directo MARYLAND N/A BALTIMORE CITY the th 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 U.S.A. 3319 EGERTON ROAD death 1 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 200 No If Yes, Give Year or Detes: Waa Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Stetus permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelth and Mentel hygiene. Important: if item 27 Is marked other than "natural", or iten any injury or other traumatic avant, the Mades Examina-Black, White, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 20XNo Specify: Specify:BLACK à Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DOMESTICE ENGINEER PRIVATE 6th grade 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FANNIE THOMPSON WEBSTER STANLEY 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3215 Northmont Rd, Baltimore, Maryland 21244 Harry Cole/Son 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Fermetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 7-13-99 BALTIMORE, MARYLAND METRO CREMATORY 21. Signeture Funeral Service License 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME PA sour 1206 W NORTH AVENUE 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final HYOCARDIAL INFARCTION IDAY disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner STAGE RENAL DISEASE 3 4 IEARS END the death certificate be executed physician and s the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es a consequence of): Box 68760, 1041SANS HYPRRIBNSION Physician/Medical that initieted events resulting in death) Last Due to (or es a consequence of): 88 for usa as 15 YIZARS CONGISSITUR ITISARVI FMUUNIS signed by the a P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown The law requires that COL A HARGIE Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s has 1 Yes 2 No 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 20€No this 28a. Dete of Injury (Month, Dey Year) funeral 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred or Attending 1 D'Eveturel 5 Pending investigation deeth. 1 ☐ Yes 2 ☐ No Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, atreet, fectory, office building, etc. (Specify) 3 after 4 \ Homicide Funeral Ditely filled hours Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) and manner as stated.

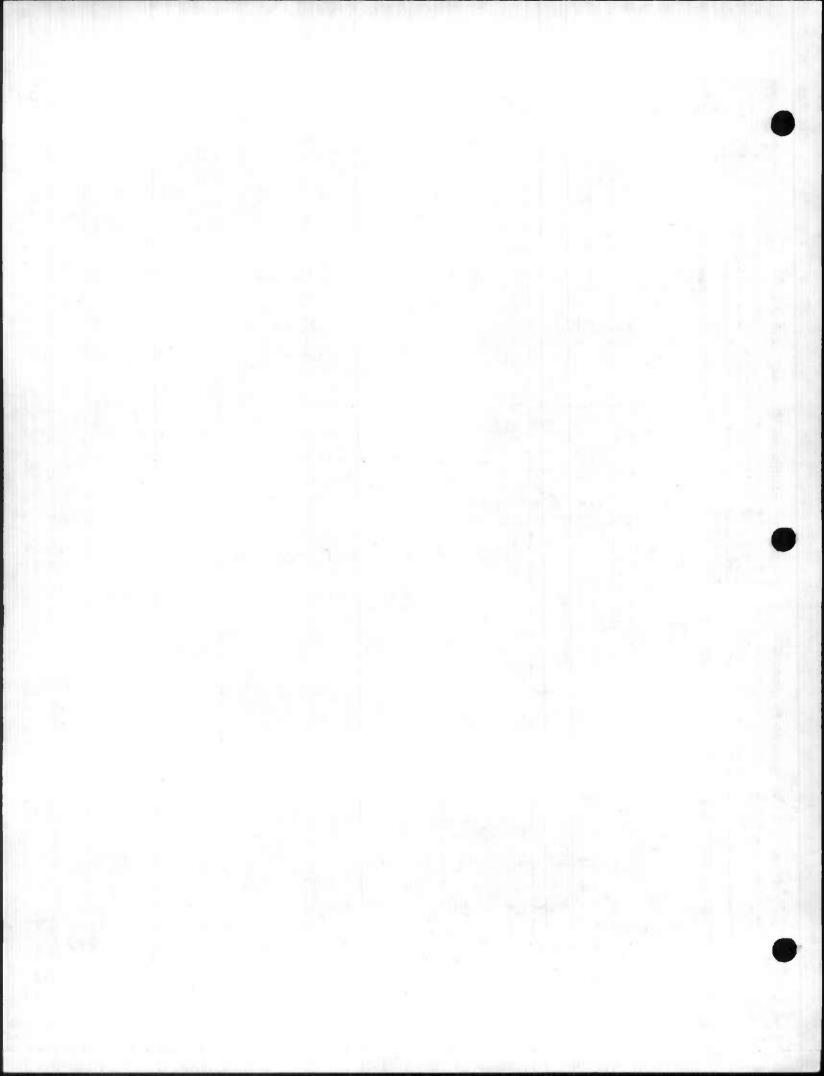
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. edical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1993 Þ CI'H JUL 10 P 175 92 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAW ALIBC ST. AGNES HOSPIME, 900 CATONALIE, BALTIMOU MAKESY MI LIMW 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 3 1999 Registrar Sparke



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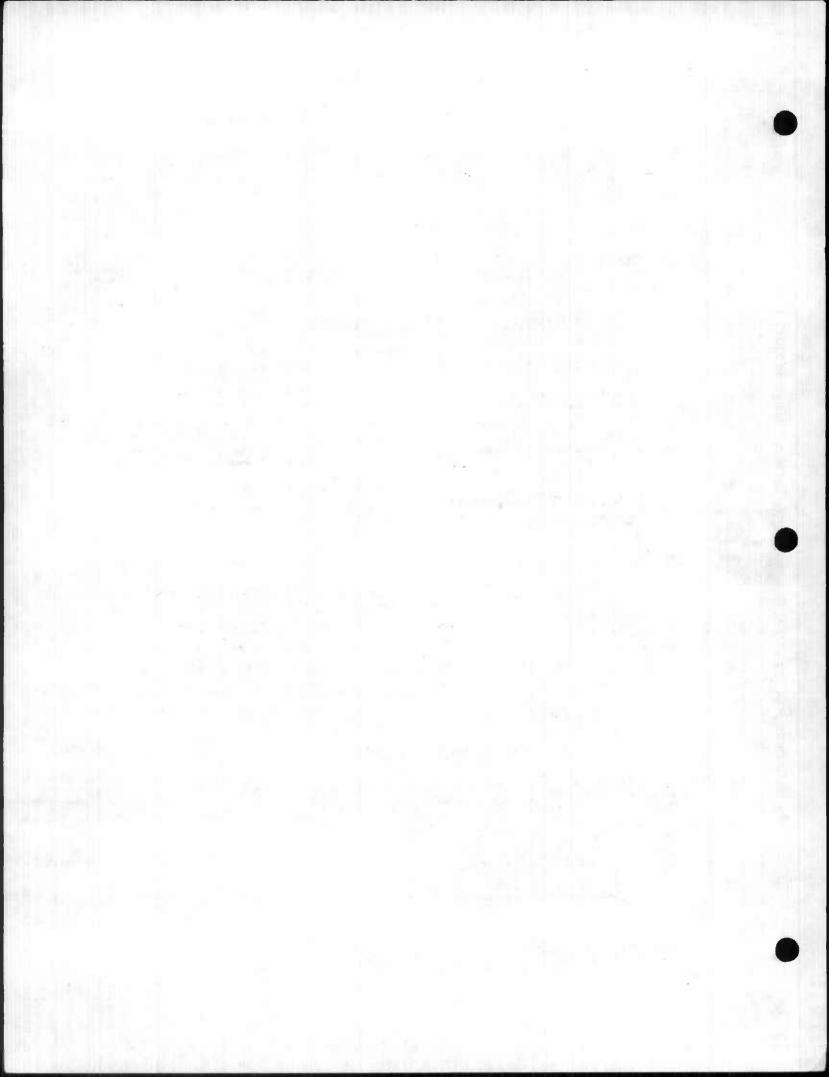
State of Maryland / Department of Health and Mental Hygiene QQ 2125

		,	Certificate of	Death	Reg. No)) (1000
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	Physician /Medical				July	9 1989	6:20PM
	Examiner	4e Facility Name (If not institution, give street and number)		4b. City, Town, or Locat		. County of Death	
		PERRING PARK GENISIS NURSING		BALTIMORE C		N/A	
L	Funeral Director	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs 1 Usual Residence of Decedent	88 Yrs. Hunder 1 Yeer Months Deys		Dete of Birth Month, Dev. Year UN 5 1911	9. Birthol Coun NORT	lace (State or Foreign H) CAROLINA
	Menyland -f ahow fled at		ity, Town or Location			10	0d. Inside City Limits
	vith the Merylan to or 28s-1 show on notified at Director	MARYLAND N/A BA	ALTIMORE CITY	10.50	10g. Ci	itizen of What Coun	1XXYes 2□No
	\$ 0 B C	1321 E. BELVEDERE AVENUE APT (212		J	J.S.A.	
020	or after or he by Eur	3 XXWidowed 4 ☐ Divorced If Yes, Give Yeer or Detes:	13. Was Decedent of It Yes, specify Cul	Hispanic Origin? (Specifoan, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - America Black, White, e Specify: BL	
21215-0020	net and	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+)	16a. Decedent's Usuel Occu (Give kind of work done life. DO NOT use retin CHILD CARE PR	during most of working ed)		Kind of Business/Ind	lustry
Maryland 2	permit. Peges 1 and 2 should be filed withir Department of Heelth end Mental Hygiene. Important: if item 27 ia marked other than marked other than any hjury or other traumatic avant, the Modes. To Be Compi	17. Father's Neme (First, Middle, Last)		18. Mother's Name (F		Sumeme)	
Mary	d 2 sho th end h 7 is me traume	19a. Informent's Name/Relationship (Type, Print) Elaine Wright/Daughter	19b. Meiling Address (Street				
e,	Heelth tam 27 other tr	20e. Method of Disposition 20b.	Place of Disposition (Neme of			ocation - City or To	
OE .	Peges ent of mt: If it ry or o	UCABuriel 2 Cremation 3 Li Hemovel from State	cemetery, crametory or other pto EDAR HILL CEMES		-15 GLE	N BURNIE,	MARYLAND
Baitimore,	pemit. Peges 1 and Department of Heelth Important: If Item 27 any Injury or other to BRG8.	21. Signature of Funerel Service Licensee	22 Name and Addr WILLIAM	ess of acility COMMORTH AVENUE	MUNITY FU	NERAL HOM	E PA
		23a. Part1. Enter the diseese, or complications that caused the dee	th. Do not enter the mode of dy	ing, such es cardiec or re	espiratory arrest,		Approximete
	Physician /Medical Examiner	shock, or heart feilure. List only one ceuse on each line. Immediate Cause (Final disease or condition	tive Hear 1 or as a consequence of):	+ Failur	e		triterval Between Onset and Death 2 4 Puss
	THE STATE OF	resulting In death) Due to (or as a consequence of):			1	2 years
	and Frans	Sequentially list conditions, Many leading to immediate	or as a consequence of):				
68760,	fificate be executed by physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	or es e consequence of):				
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Records,	aw requir				24a. Was an auto performed?	ava	era autopsy findings ailable prior to mpletion of cause death?
E H	yelclen: The law is certificate hes director, page 2				1 ☐ Yes 2	1 De No	Yes 2 No
Vital	sician irector o Be	Hospitel		26. Place of Deeth (C			
of	2 0 0	1 Inpatient 2L	28b. Time of Injury 28c. Injury We	4 (2) Nursing Home	5 ☐ Residence d. Describe how injute	6 ☐ Other (Specif) ury occurred	<u>v)</u>
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	To the Hospital or within 24 hours after To the Funeral Dirt completely filled in Medical Cert	29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the best of my kn. (Check only one) 1 ✓ Certifying Physician: To the best of my kn. (Check only one) 1 ✓ Certifying Physician: To the best of my kn. and manner stated.	owiedge, death occurred et the tation end/or investigetion, in my	ime, date end place, end opinion, death occurred	due to the cause(: et the time, date ar	s) and mannar as st nd place, and due to	tated. the ceuse(s)
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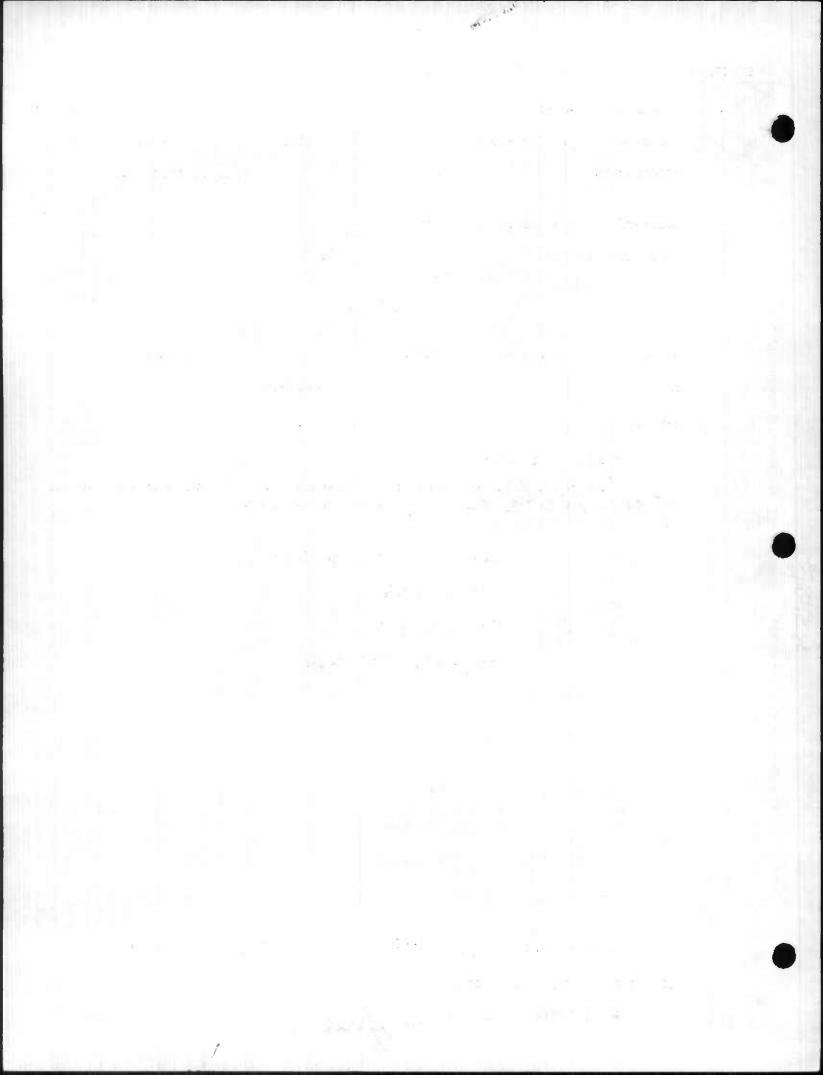


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/Med Exam		4a Facility Neme (If not ins	stitution, g	ive street end		.ancy				or Location of D	eath 4c.	County of Deat	th
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Funera	1	5. Social Security Number		Sex	7. Age ((In yrs. last be		If Under 1 Year Months Deys	r If Under 24 i	Hrs. 8 Date of	Birth Year	9. Birt	hplaca (State or Foreignanty)
Director		223-16-529	94	1 🖾 M 2 🗆 I		90	Yrs.	Months Deys	Hours A	Ain. (Month,	Day, Year)		· C ·
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28e-f	ct	MD	NA			Balt	timo	re					1 X Yes 2 □ N
with the Maryland a or 28a-f ahow be notified at	Director	10e. Street and Number						10f. Zip Code			10g. Citiz	zen of Whet Co	ountry?
me 23a	8	2848 West	Mul	berry	Stre	eet #:	23_	212				U.S.A	•
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To the Hospital of Atlanding Physician: The law requires that the death certificate be executed to within 24 hours after death. Ye the Funeral Director: After this certificate has been signed by the atlanding physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit or	edical Certification: To Be Completed by Physician/Medical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Part II. Other significant or examiner? 1 Yes 2 No 27. Manner of Death Netural 5 F Accident 3 Suicide 4 Homicide 29e. Certifier (Check only one) 29b. Signatum and title of or	pending nvestigatic fetermine artifying Pedical Examples of the person who are the person	a. Accontributing to the description of the end of the	Inpatient ete of Injury ilding, etc. (ue to (or as a last to	consequence of the street of t	ance of): derlying cause of the mode of dy ance of): derlying cause of the derlying c	ing, such es car	23b. I 24a. V p 24a. V p 25b. I 25c. I 26c. Description 28d. Description 2	old tobacco of the cause(s) ine, date and	use contribute No 3 P sy 24b. Contribute No 3 P sy 24b. Contribute	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset



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ı	Funeral Director	7	577-40-2353 1□ M 21	W.	6 Yrs.	Months Days	Hours Min.	8. Dete of Birth (Month, Day, Dec. 1,	1912 D.	Birthplace (Stata or Fora Country) C.
	p s		Usuet Residence of Decedent 10a. Stete 10b. County	10c Cit	y, Town or Loc	cation				10d. Inside City Limi
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	the N	Director	Maryland Prince Geor	ges Cli	Inton	10f. Zip Code		1	0g. Citizen of Whe	t Country?
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Baltimore,	Pages hent of H ant: If Its		20e. Method of Disposition 1 Buriel 2 Cremetion 3 Remove 4 Donatton 6 Mother (Specify) 11	I from State		sition (Neme of setory or other ple	ca)	Date	20c. Location · City	y or I own, Stete
Balt	Departition of the series of t		21. Signature of Funeral Service Licensee Ronald S	de, Direct	or St		omy Board		. Baltimo	ore Street
	-05 c 1	4	23e Pert1. Entar the disease, or complications shock, or heart feilure. List only one caus	thet coused the deet	h. Do not ente	ltimore or the mode of dy	MD 2120		est,	Approximete Interval Between
¥	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth)	Conges						Onset and Death
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			resulting in deeth) Lest	Bipol	MAC (desia	0			
Box	death certific e ettending p od for use es	an	d	13/10/	cop c	man.				
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of V	S 00 0	2	examinar? 1 ☐ Yes 2 ☒ No Hospital	1 Inpatient 2 □	ER/Outpetien	3□ DOA O	her: 4 Nursing H	ome 5 Reside	ence 6 Other	Specify)
iono	Iling After fune		27. Menner of Deeth 1 Neturel 5 Panding 2 Accidant Investigation	Dete of Injury (Month, Dey Year)	28b. Time of Injury	M 1	nyet ork?]Yes 2∐No	28d. Describe ho	ow injury occurred	
Division	X = = C	Certification:	3 Sulcida 6 Could not be determined 28e.	Place of Injury - At he building, etc. (Specify	ome, farm, stre	eet, factory, offica		28f. Location (Si City or Town		or Rurel Route Number,
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edical (29e. Certifier (Check only one) 1 Certifying Physician: 2 Medicat Examtner: One one	To the best of my known the besis of exemined dimanner steted.	wledge, deeth tion end/or tnv	occurred at the ti estigetion, in my	me, date and piece, opinion, deeth occur	end due to the cred et the time, d	euse(s) and menne ate and plece, and	er es stated. I due to the cause(s)
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			ALI RAHIMIAN, SOUTHERN MD.							
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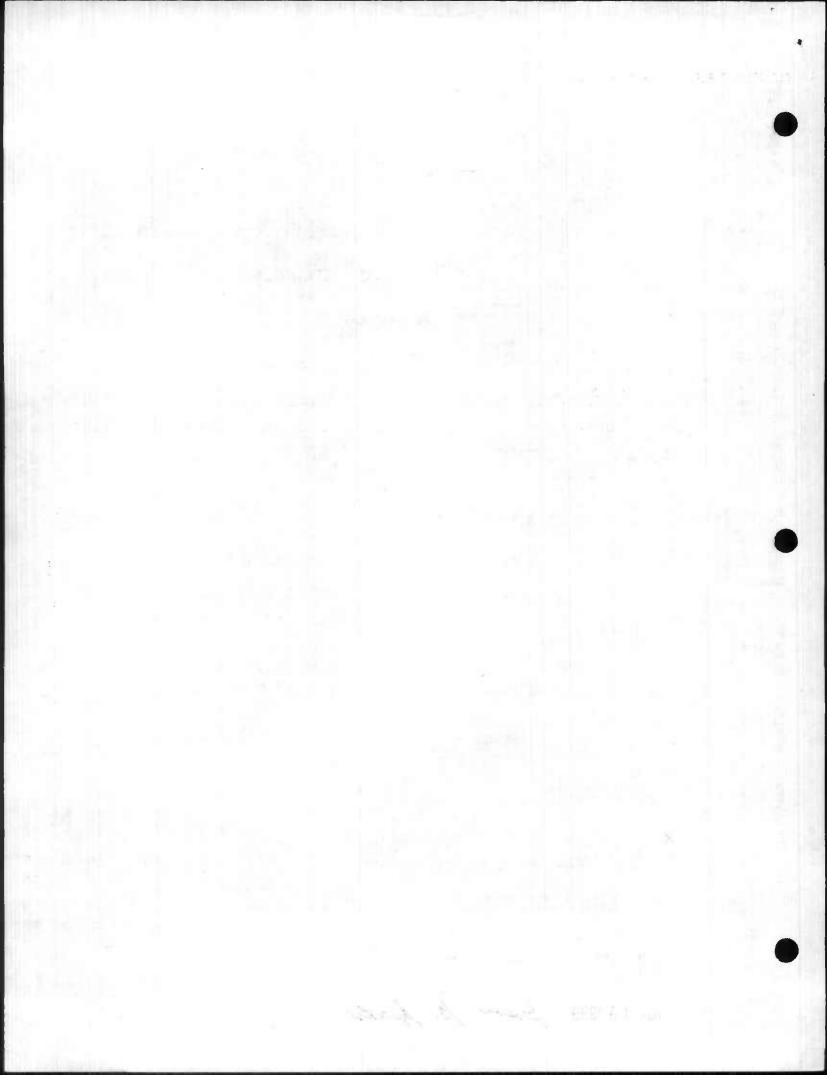
99-3871-510 DONALD CARTER Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ASP Certificate of Death FH G773 7/13/99 AH

1. Decedent's Nama (First, Middle, Last) Reg. No. AMENDED ITEM #7 PER 2. Data of Death 3. Tima of Death Month JULY **Physician** 06 1999 ARTER 2:18 A) ON ALD /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BON SECOURS HOSPITAL BALTIMORE NIA If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours 10M 20F 219-32-9374 MD Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits rthan "natural", or itema 23a or 28a-f ahov the Madical Examiner must be notified at 1 ☑ Yas 2 ☐ No N Director IA BALTIMORE MO 4 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? YFAYETIE 21217 death Funeral 12. Was Decedent Evar in U.S. Armed Forces?

1 1/2 Yas 2 1/2 No If Yas, Giva Year or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Btack, Whita, atc. pernit. Pages 1 and 2 should be filed within 72 hours after Copartment of Health and Mental Hygiene. Important: If fern 27 is marked other than "natural", or feel any fujury or other traumatic event, the Medical Examine Bate. 1 Never Married 2 Married 21215-0020 1□ Yas 2☑ No Specify: Specify: à 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Uaual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TH GRADE NIA HOME IMPROVEMENT AINTER Baitimore, Maryland 17. Father'a Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be HARLES CARTER ouis 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) CARTER AYFAYETTE BALTO TAYE MD 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata MEMORIAL 7-12-99 KANDALLSTOWN, MD MARK 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility
VAUGHN C. GREENE FUNERAL SERVICE 23a. Part1. Enter the displace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BALTO. Approximata Intarval Between Onset and Death Physician /Medical Immediata Causa (Final disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease Examine Dua to (or as a consequence of): physician and the burlet-transit Examir The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760 Physician/Medical Dua to (or as a consequence of): signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown Records, þ should t 24b. Wara autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? INSPECTION page 2 1 Ves 2000 1 Yas 2 No Division of Vital after death.
Director: After this certific 8 25. Was casa refarred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1XYes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ◯X DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending invastigation 1 Naturat 2 Accident 1 ☐ Yas 2 ☐ No 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, tarm, street, factory, office building, atc. (Specify) 4 Homicide filled ! 24 hours 1 Certifying Physician: To the best of my knowledga, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Certifier edica To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and 48te of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E JULY 06,1999 ddress of person who Paysa of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 ose ane 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State 1 3 1999 JUL parks Registrar

T DHM



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** ELEANOR W. COLTON 1999 Jul /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Good Samaritan Nursing Center N/A If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🛣 F Days 193-18-0267 78 Pennsylvania Director July 6, 1921 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or liente 23a or 28a-f show the Medical Examiner must be notified at N/A Baltimore City 1 X Yes 2 □ No Md. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2604 Hamilton Avenue 21214 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black White, etc. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Py White 3 Ø Widowed 4 □ Divorced Completed 16s. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7. Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be the Department of Heath and Mental Hy important; if ten 27 is marked othe any Injury or other trasments. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Bunja Mary Horani 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 2604 Hamilton Ave. Baltimora, Md. Madeline L. Robinson (Sister) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 7/10/99 New Cathedral Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee Milton J, Knight Jr 22. Name end Address of Facility LeonardJ. Ruck Inc. Wilton 23a. Pert1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 5305 HarfordRoad Baltimore, Maryland 21214 Approximate Interval Between Onset and Death **Physician** CARCINOMA OF GROST, METESTOTIC /Medical Immediete Cause (Finel diseese or condition resulting in deeth) Examiner Due to (or es a consequence of) Examin physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown rac Terry DISCOSE Columnia by 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? 1 Yes 2 2 No 1 □ Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this 28a. Dete of Injury (Month, Day Year) 27 Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred ve Hospital or Attending P in 24 hours after death. Certification: After 1 Netural
2 Accident 5 Pending investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide To the Hospital o within 24 hours at To the Funeral DI completely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one) 29b. Signature and the contile 29c. License number 29d. Date signed (Month, Day, Year) 20390 30. Name and address of person who completed cause of death (frem 23a) (Type, Print)

AHB

DHMH 16 Rev 6/95

State Registrar mo

9712 BECOM RD

Brown ma 21236

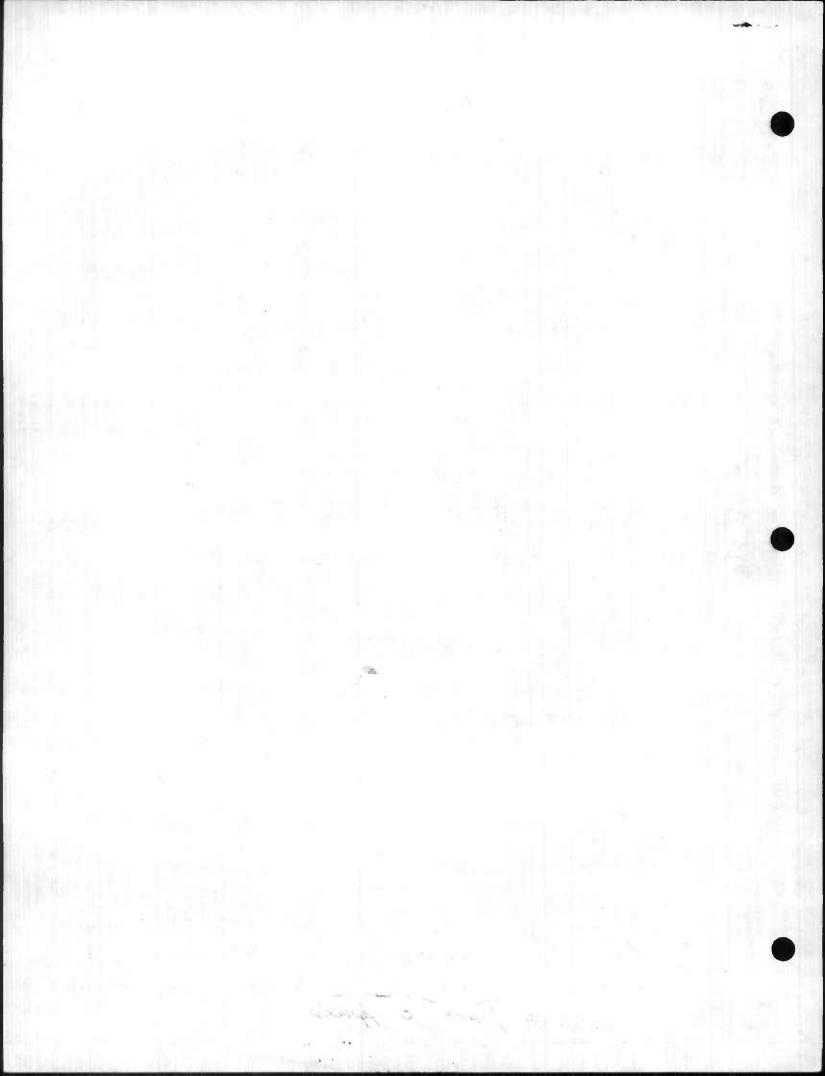
HOESCIA

32. Registrar's Signature

CHANCOS

1 3 1999

31. Dete filed (Month, Day, Year)



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Pecedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death 1130 Month 1999 4a Facility Nama (II pot institution, giva street and number) ul 4b, City, Town, or Location of Death 4c. County of Death 1+imore DONADAR+ AVE. E If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 6, 1919 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 19M 20 F 248-28-4548 Yrs South C Usual Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No TIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 ONADARTE 4 LENNE 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status Black White etc. 1 Nevar Married 2 Married 1 Yas 2 V If Yas, Give Yaar or Datas: 2 NO 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry HARDISON-WALKER Elementary/Secondary (0-12) Collega (1-4or 5+) KER REFRACTORIES 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) nomas ADERS Sheel u MAN 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) WiF BAHO. BONAPARTE ADERS July 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State BAltimore 4 ☐ Donation 5 ☐ Othar (Specify) 18,1999 21. Signature of Funeral Service Lices 22. Nama and Address of Facility NUHER & SONS FUNERAL HOME GWXNNS FALLS PKWY-BALLO, M.D. 21216 2501 23a. Pet 1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Deat Immediata Causa (Final disaasa or condition rasulting in death) > I year (exebrovascular) 2 secro Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disease or injury that hitiated evants rasulting in daath) Last Due to (or as a consequence of): Dua to (or as a consequence of): Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23h. Did tohecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? notein energy malnutration completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was casa rafarred to medical examinar? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Pasidence 6 Other (Specify) 1 Yas 2 No 27. Mannar of Death 1 D Naturai 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No invastigation 2 Accidant 6 Could not be datamined 28a. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 4 Homicida

Box 68760 Records, Vital 6 Division Attending 24 hours after deaf a Funeral Director: 8

Physician

/Medical

Examiner

Director

Funeral

Completed

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Funeral

Director

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altimore, Maryland 21215-0020

Pages 1 and 2 should be nent of Health and Mental is marked

important: If Item 27 any injury or other to

Physician /Medical

Examiner

Completed by Physician/Medical

Be

Certification: To

edical

29a. Certifie

(Check only one)

29b. Signatura and titia of certifier

31. Data filed (Month, Day, Year)

After

To the P within 2 To the P

DHMH 16 Rev 6/95

State Registrar

JUL 131999

Boston

sodon MI

30. Nama and address of person who complated causa of death (Item 23a) (Type, Print)

E. University 32. Registrar's Signatura

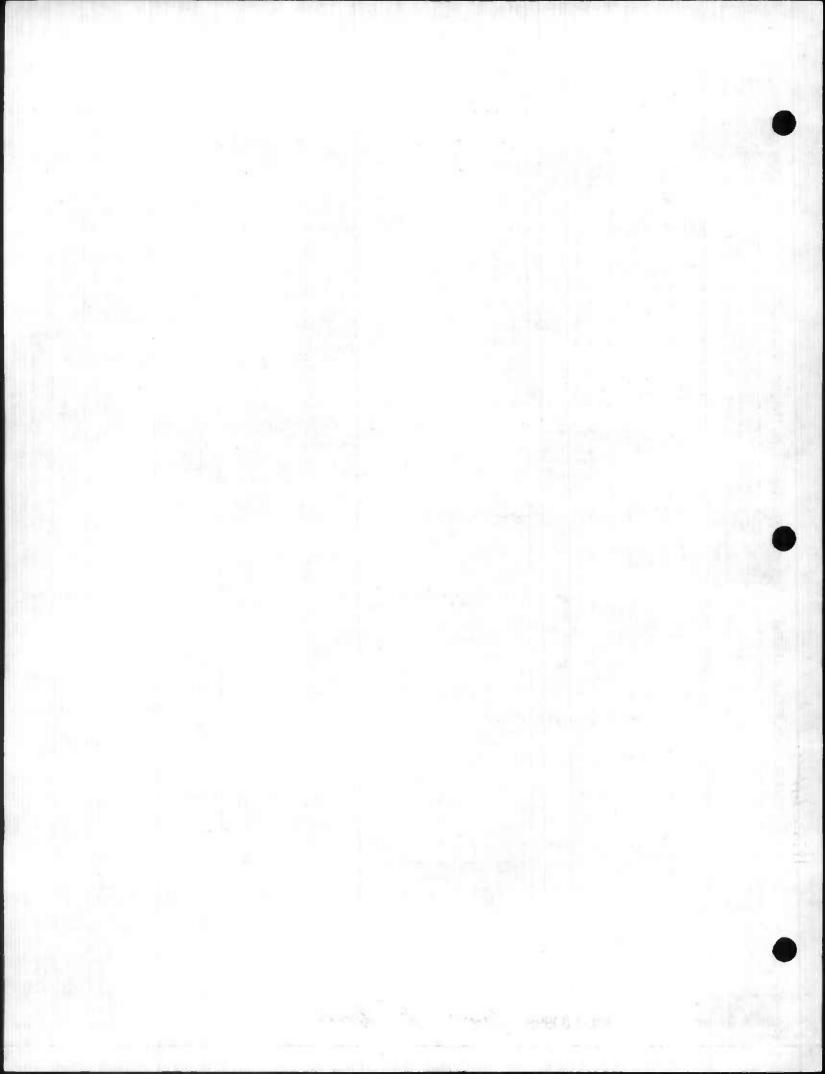
Parkway

1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D 28462

29d. Data signed (Month, Day, Year)

Union Memorial Hospital



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** 11.40 AM Barbara J. Donnelly 1999 JULY /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner Ghen Burne Appar If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)
Dec. 15, 1930 NoR+H ARUNDEL 5. Social Security Number 6. Sex HOSPITAL ARUNDEL ANNE Birthplace (State or Foreign Country)
 New York If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2XF Months 555-38-0406 68 Director Usual Residence of Deceden 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ? Is marked other than "naturel", or hems 23s or 28s-f show traumetic event, the Medical Examiner main be notified at Maryland Anne Arundel Co. 1 ☐ Yas 2 No Director Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8406 Sultan Drive 21122 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Detas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Raca - Amarican Indian 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 N/A permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy, important; if them 27 is marked other any Injury or other. 18. Mother's Name (First, Middle, Meiden Surnama) 17. Father's Name (First, Middle, Last) Be Walter Ekenberg Hortense Bauschman 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) James V. Donnelly Husband 8406 Sultan Drive Pasadena, Maryland 21122 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) GreenMount Crematory July 9,1999 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility
McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Pert1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart leiture. List only one cause on each line. Approximete tnterval Between Onset and Death Physician /Medical Immediate Cause (Finet disease or condition resulting in death) MYOCARDIAL INFARCTION Examiner Examine ENCEPHALOPA physician and the buriei-transit Box 68760. Physician/Medical Due to (or as a consequence of)

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

24b. Were autopsy findings evailable prior to complation of cause of death? 24a. Was an autopsy performed?

1□ Yes 20 No

1 Yes 20 No

25. Was case referred to medicat axaminer? 1 Yes ZE No

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Deeth (Check only one)

HUSTITAL MD

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

29a. Certifier (Check only

27. Manner of Death

1 Matural
2 Accident

3 ☐ Suicide

4 ☐ Homicide

by

Completed

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Certification:

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as atated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier MI 29c. License number 051245

1 Yes 2 No

29d. Data signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARUNDER NONTH

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUL 1 3 1999

6 Could not be

DHMH 16 Rev 6/95

State

Registrar

To the Hospital or Attending Plantin 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral

After

BARBARA J.

Records. P.O.

Division of Vital

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 158P11 1999 MYRA L DESOMBRE 4c. County of Death 4a Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Baltimore Franklin Square enter osedale bita HOS If Under 24 Hrs. If Under 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (n yrs. last birthday) Social Security Number Say Hours Months Days Min. 1 M XXX 214 30 2655 Yrs. 67 Nov.20 1931 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Md. Essex 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 365 Mitchell Road 21221 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes > No Specify: specify: White 3 Ø Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Busineas/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Frizzel George M Baier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 300 Margaret Ave. Baltimore Md. 21221 Matthew Desombre / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 7/8/99 Baltimore Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home of Essex 300 MAce Ave. Baltimore Md. 21221 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Carc Due to (or es a consequence of) Arter oronar 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? 2 X No 1 ☐ Yes 2 ☐ No 1 Yes 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

The law requires that the death certificate be executed P.O. Box 68760. Records, Division of Vital

Physician

/Medical

Examiner

Director

Funerai

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Completed

Funeral

Director

d 2 should be tiled within 72 hours efter death with the Marylen th and Mentel Hygiene.
7 is merked other then "natural", or frems 23s or 28s-1 show traumstic event, it a Medical Examine time to notified.

Peges 1 end 2

of Heafth important: If Item 27 any Injury or other to

Department

Physician /Medical

Examiner

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Certification:

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or Attending Physician: death. within 24 hours efter death To the Funeral Director: completely filled in by the

> State Registrar

31. Date filed (Month, Day, Year) 3 1999

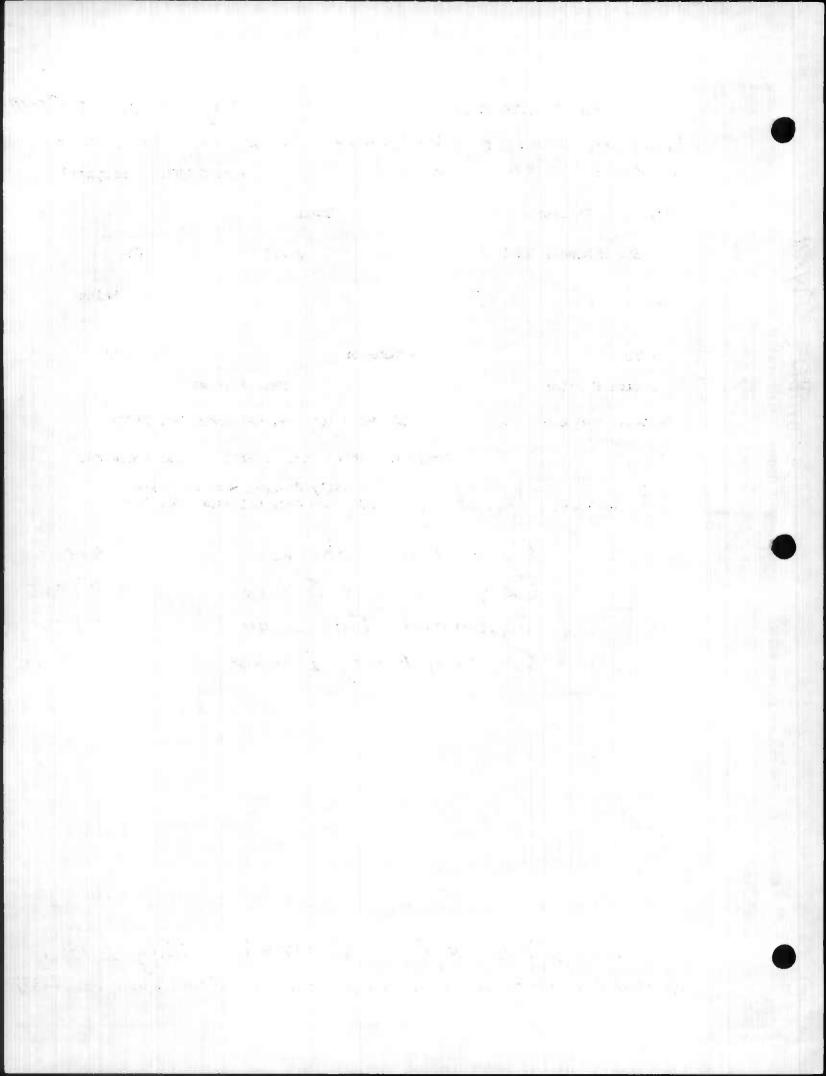
29b. Signature and title of certifier

29d. Date signed (Month, Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR AASMA ShEIKh

Square Drive Baltimore, Maryland 9000 Franklin 32. Registrar's Signature

29c. License number



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within \(\frac{74}{24} \) hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 sh be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be nettified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - FOR STATE REGISTRAR	STATE OF MARYL		ENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIENE REG. NO.		
		y Doyle (Jacob I	Daniel)	2. DATE OF DEATH	99 YEAR	3. TIME OF DEATH 6=22 p m
	4. SOCIAL SECURITY NUMBER	198.M 2 □ F	-YRS MOI	UNDER 1 YEAR IF UNDER 24 HRS. ITHS DAYS HOURS MIN. 1 8	7, DATE OF BIRTH (Month, Day, Year) 7/4/99	Me	aryland
HOIS	99. FACILITY NAME (If not institution, give :	Baltimore Media		Baltimore Mar	4	9c. COUNTY OF	
DIRECTO	Maryland 10b. COUNT	N/A		own or location			10d. INSIDE CITY LIMITS? 1XXYES 2 NO
NEHAL	15 Egges La			101. ZIP CODE 2 1 2 2		US	WHAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 X Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	13. WAS DECENDENT OF HISP/ If yes, specify Cuben, Maxic 1 YES 2 NO Spec	an, Puerto Rican, etc.)	Bla	CE — American Indian, ck, White, etc.
PLEIEU	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) N/A		16e. DECEDENT'S USU (Give kind of work life. Do NOT use rel	done during most of working	166. KIND OF BUSI		
BE COMPL		James Doy		She	AME (First, Middle, Maiden S ila Ann	Clift	on
2	NIKKI CHILCOAT	(6701 N	• CHARLES ST	REET, TOWS	ON, MAR	
	20e. METHOD OF DISPOSITION 1 Surial XIX Cremation 3 Rem 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE			7-8 BAL	SONS C	.,21202 OMPANY
FRIITICATION	sindex, or near value. iMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	b. DUE TO (OR AS A	A CONSEQUENCE OF):	by			Interval Between Onset and Death
MEDICAL CI	PART ii. Other algnificant condition	is contributing to death b	out not reaulting in th	ne underlying ceuse given le	Part i. 24a, WAS AN A PERFORM	NED?	b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
II TOICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	RIBUTE TO CAUSE C	26. PLACE OF DEATH (C				
101	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF		26d. DESCRIBE HOW IN	JURY OCCURED	
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spe-	f — At home, farm, atreet	t, factory, office	28f. LOCATION (Street en City or Town, State)	nd Number or Rural	Route Number,
CMTLE				the time, date and place, and du my opinion, death occured at the			(a) and menner as stated.
IO BE	296. SIGNATURE AND TITLE OF CENTERE SUPPLY STATEMENTS OF PERSON WH	on mo NI	CCU Pedadricia EATH (ITEM 27) (Type, Prin	29c, LICENSE NU	MBER GUSO	29d. DATE SIGNE	D (Month, Day, Year)
		Fin Take Court 32/REGISTRARS SIGN	Darre Hadl				

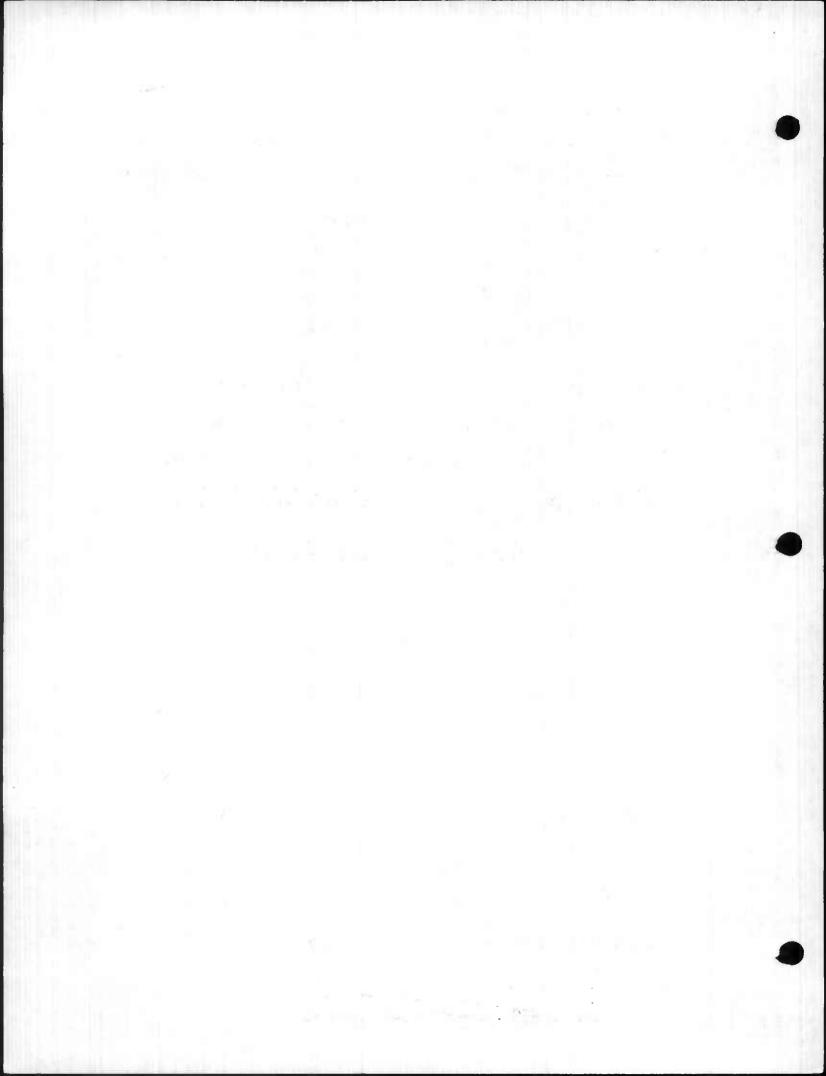
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland	Department of Health	and Mental H	lygiene 9	9	21

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JULY 1999 CATHERINE L. DAVIS 11 6:40am /Medical 4a. Facility Nama (If not Institution, give straat and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 105 WENDOVER RD BALTIMORE If Undar 1 Yaar 8. Date of Birth (Month, Day, Year) 9. Birthplaca (State of Country) 09/16/1908 MARYLAND 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** Days Months Hours 1 □ M 28 F Yrs. 90 Director 216-46-6047 Usual Residence of Decedent the Marylend 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-1 show 7 is marked other than "natural", or items 23a or 28a-1 show traumatic event, the Medical Examinar must be notified as 1 Yes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 WENDOVER RD 21218 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Dacedant Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 11 Markal Status filed within 72 hours after Hygiene. 1 ☐ Yas 2 Mo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: þ 3 ₩ Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) s 1 end 2 should be filed w Health end Mental Hygier tem 27 Is marked other th 12yrs HOUSEWIFE HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be EUGENE LAZENBY JESSIE BRIGGS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stata, Zip Code) permit. Pages 1 end 2 Department of Health e Important: If Item 27 Is any Injury or other tras ARTHUR E. DAVIS III(SON) 2 WYNDHURST AVE. BALTO., MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 Cramation 3 Removal from State 07/16/99 BALTO., MD. 4 ☐ Donation 5 ☐ Other (Specify) LOUDON PARK CEM. 21. Signature of Funaral Service Licenses 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212. 60,00 aux III 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760. physician The law requires that the death certificate be Physician/Medicai the Due to (or as a consequence of): SS USB 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. the signed by t 1 be detech 1 Yes 2000 3 Probably 4 Unknown by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed peen completion of causa of death? page 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes Other: 4 Nursing Home Residence 6 Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) uneral 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Hospital or Attending P 124 hours efter death.
 Funeral Director: After ti Certification: After 5 Pending 1 Yes 2 No Investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide In 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Within 2 29b. Signature and title of certifie 29c. Licansa number 29d. Data signed (Mghth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IGLEHART M.D. I.W. 500 WEST UNIVERSITY PKWY. BALTO., MD. 21218. 32. Registral's Signature 31. Date filed (Month, Day, Year) State

Registrar



Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Dolores Dean JUU /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Deaton University of Medicine If Under 1 Year 24 Hrs. 8. Date of Birth (Month, Dey, Year) Pt. Name: Delores Anna New Maryland 5. Social Security Number 7. Age (In yhs. last birthday) **Funeral** 1□M 2XF Months Deys Hours 213-82-3948 74 **Director** Jan. 17, 1925 Usual Residence of Decedent with the Marylend 10a. State Md. 10b. County 10c. City, Town or Location w 28a-f show ehow Baltimore Reisterstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d 2 should be filed within 72 hours efter death with th and Mental hygiene. 7 is marked other than "natural", or frame 23a or traumatic event, in Mental Examine must be a 18 Cedermere Dr. 21136 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Merried 1 Yes 2 No Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Never Worked Never Worked 0 Yrs 18. Mother's Neme (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be found to Health and Mental Int: If Item 27 is marked of Harry B. Dean Laura V. Webb 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ida Koneyak sister 1517 Leslie Rd. Dundalk Md. 21222 other 1 20b. Pleca of Disposition (Name of cemetery, crematory or other placa) 20c. Locetion - City or Town, State 20a. Method of Disposition July13 important: If he any injury or o 1 Burlel 2 Cremation 3 Removal from State Meadowridge Mem. Gar. 1999 4 ☐ Donation 5 ☐ Other (Specify) ture of Fundral Service Licen 22. Name and Address of Facility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 Iter the disease, or complications they caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest of heart failure. List only one cause of each line. **Physician** /Medical Immediate Cause (Final home Obstuctive diseme disease or condition resulting In death) Examiner Due to (or as a consequenca of): Ketandahm mente / Examin that the death certificate be executed physician and s the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es a consequence of): Osphetou evilue Box 68760. Physician/Medical (or as a consequence of): attending pl ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed be should be defe Division of Vital Records. by The law requires Completed

744-8 Venhater dopardal 7 may 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? 1 Yes 2 No 1 Yes 212 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30494 7/10/99 30, Name and address of person who completed cause of deeth (Item 23a) (Type, Print) K DESHIM Dean Medical Center GI south charles St Baltonne MJ21230

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q

3. Time of Death

C:20 AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximete Interval Between Onset end Death

1 ☐ Yes 2 No

1999

USA

14. Race - American Indian, Black, White, etc.

Specify: White

Howard Co.

4c. County of Deeth

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Registrar

31. Date filed (Month, Day, Year) JUL 131999 32. Registrar's Signature

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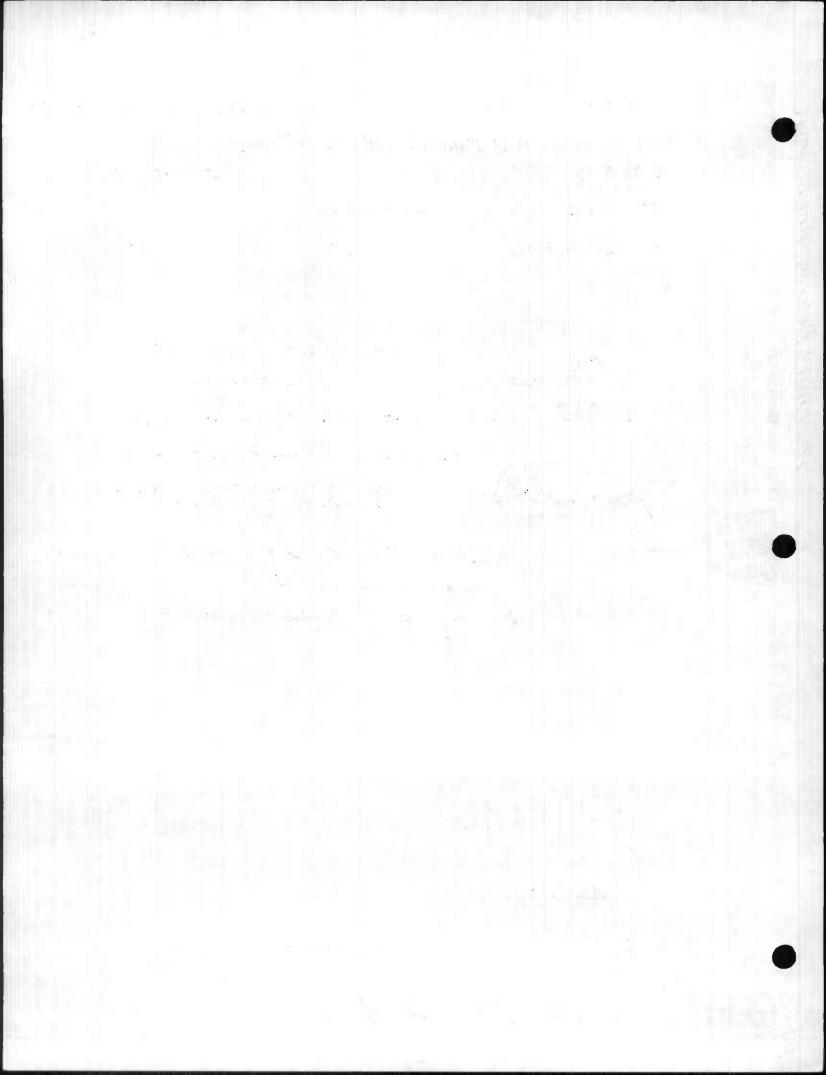
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r than "natural", or items 23s or the Wedical Examiner must be a

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic svent, the Medical Examinations.

altimore, Maryland 21215-0020

the Maryland

death

Examiner Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or tnjury that initiated evants rasulting in daath) Last Physician/Medicai

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yas 2 No 27 Mannar of Death

5 Panding Invastigation

6 Could not be datamined

28a. Data of tnjury (Month, Day Year)

28b. Tima of

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work?

1 ☐ Yas 2 ☐ No

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 28d. Dascribe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartiflar (Check only one)

1 Natural
2 Accidant

3 ☐ Suicida

4 Homleida

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

| Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) end menner stated.

29b. Signature and title of certifier launa

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29c. Licansa number 50847 29d. Data signed (Month, Day, Year) 99

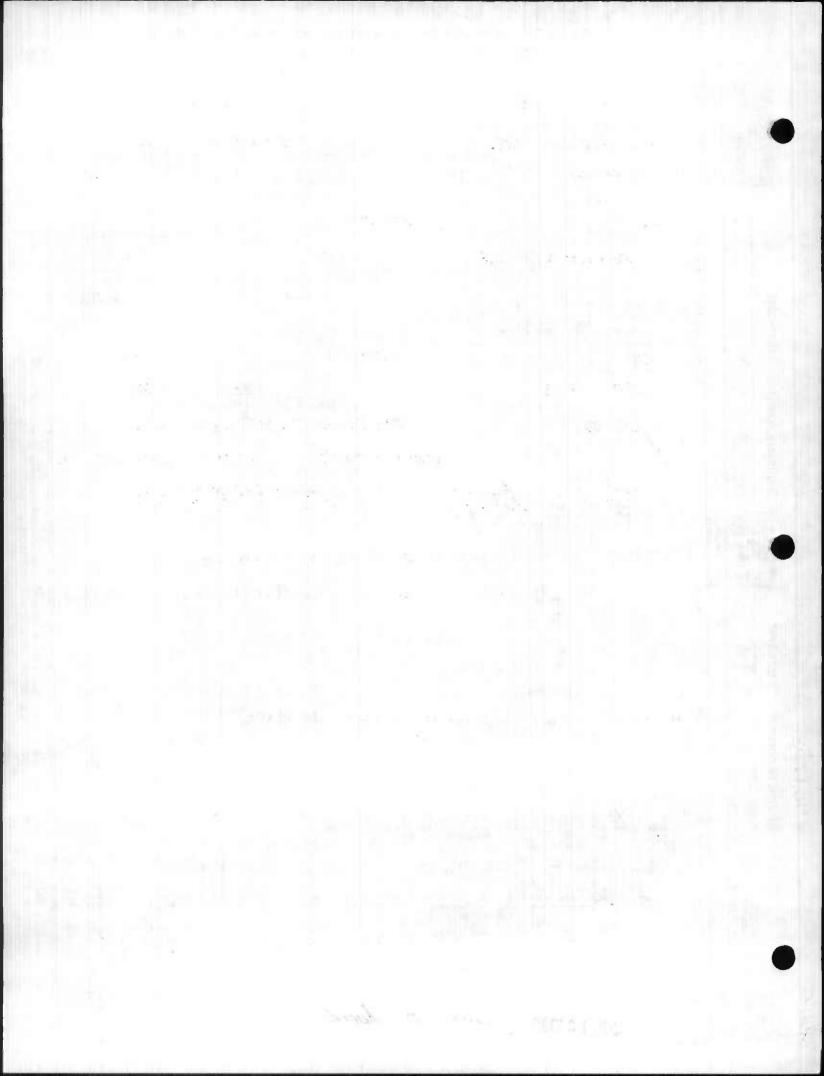
30 Nama and address of parson who complated causa of death (Itam 23a) (Type, Print)

State Registrar

31. Data filed (Month, Day, Yaar)

32. Registrar's Signatura

Sports



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Warren Lincoln Earll 8, 1999 9:11PM JULY/Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□F 130-16-2169 Director April 16, 1922 Brooklyn, New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2XXNo Directo Maryland Baltimore Sparks 28a-f 10e. Street and Number 10f. Zio Code 10n. Citizen of What Country? 19 Rainflower Path Unit 103 21152-8738 United States of America 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 12 Yes 2 □ No If Yes, Give Yeer or Detes: W.W.II 1 Never Married 2 Merried 21215-0020 1 Yes 2 XNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Sales Representative Lumber 12 Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental To William L. Earll Norma Chichester 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) or other traus Mrs. Dorry(nee Jones)Kinder Earll(Wife) 19 Rainflower Path Unit 103 Sparks, Maryland 21152-8738 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 XBuriei 2 Cremetion 3 Ramoval from Stete 7/15/1999 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Othar (Specify) Loudon Park Cemetery 21. Signeture of Funeral Service Licensee Jeffrey L. Gair 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. air 1050 York Rd. Towson, Md. 21204 ent. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such es cardiac or respiratory arrest, hock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** P.PRILLATION /Medical immediate Cause (Final VENTRICULAR LOURS SUSTANUEL disease or condition resulting in deeth) Examiner INPARCIZON DUP2 (Examiner MYOUREDIA ていて ician and buriel-transit that the death certificate be executed Sequentietly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in daeth) Last Due to (or as a consequence of): 40010MBPATHY physician Box 68760 Physician/Medical the the Due to (or es a consequence of) NULAR 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. O 1 Yes 2 No 3 Probably 4 Unknown 0 Records, þ Sign De 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division Naturel Attending 5 ☐ Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after deat Funeral Director: 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Pleca of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 6 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. edicai 29e. Certifier 2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Neme and a lidrass of person who complated causa ot death (Item 23a) (Type, Print) AVIN CHOL 6.

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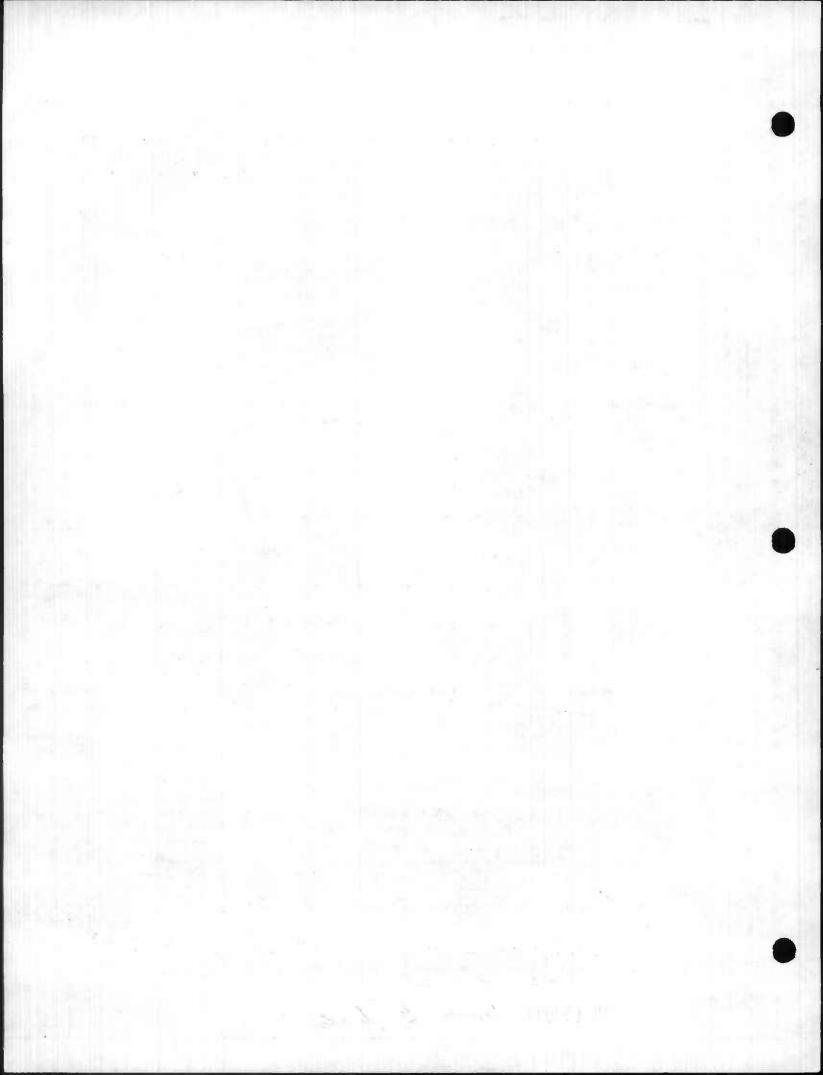
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31. Dete fited (Month, Day, Year)

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32. Registrar's Signature



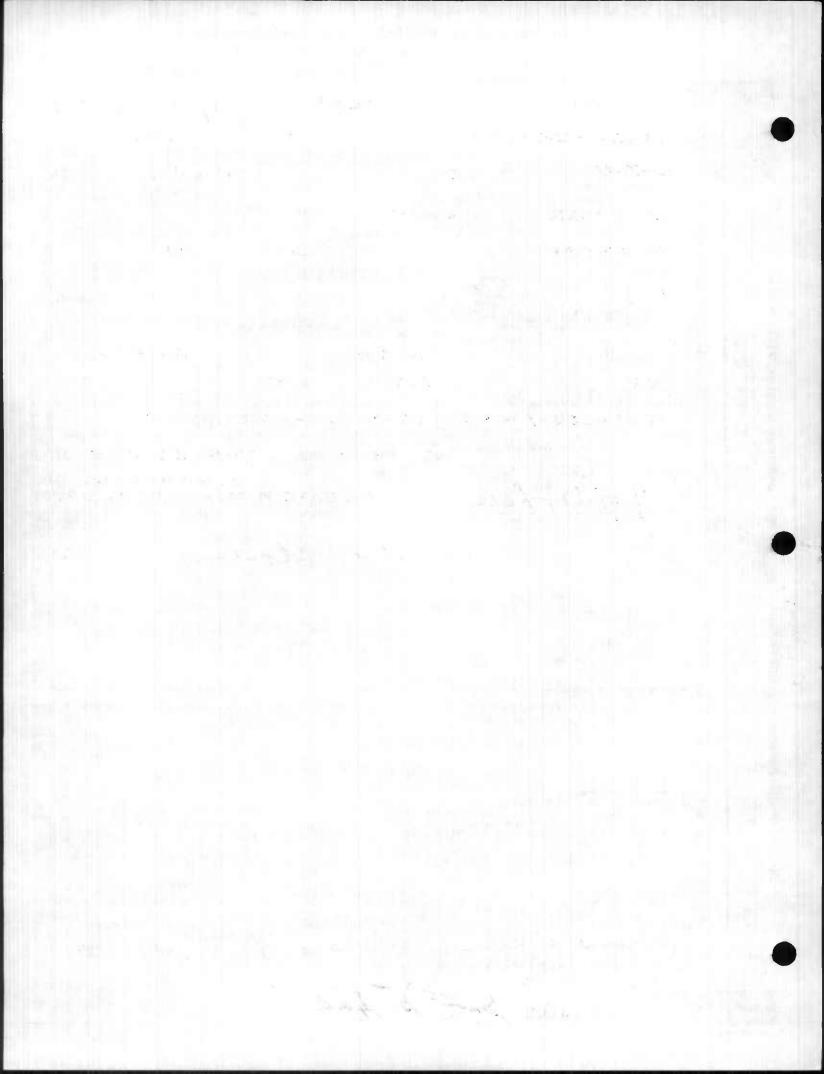
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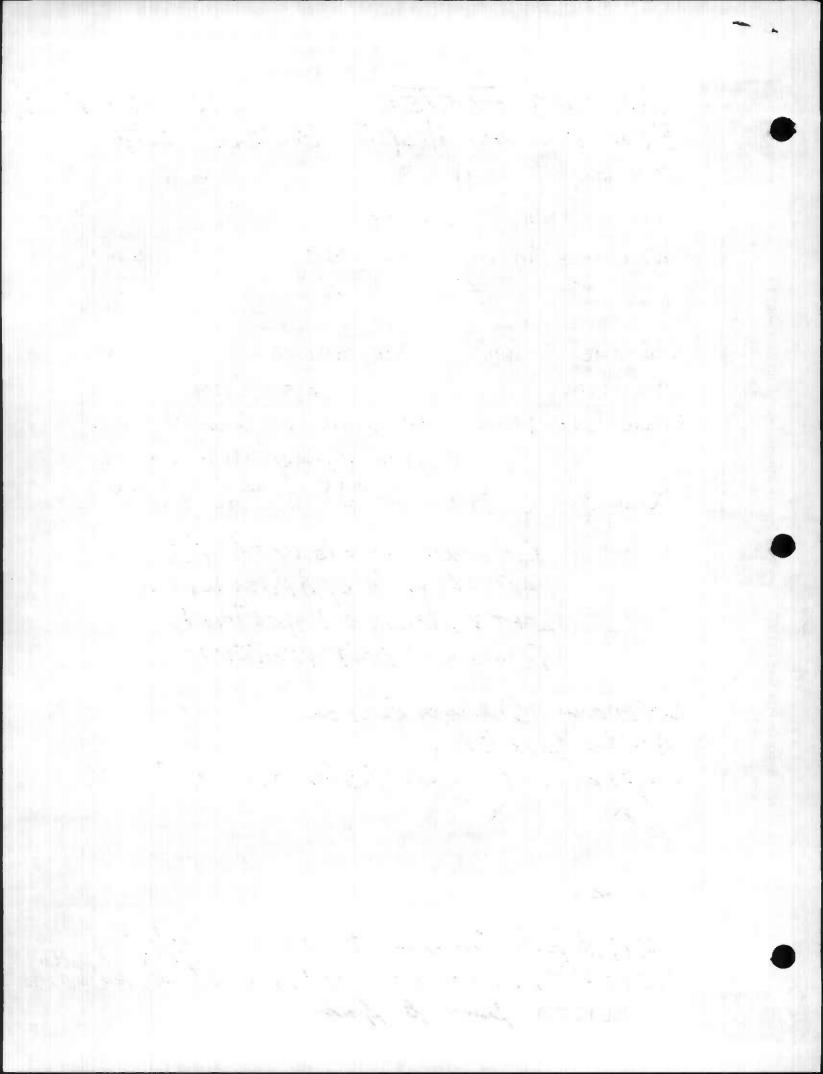


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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🖣 🖓 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mont **Physician** U /Medical City, Townyor Location of Death 4c. County ity Name (If not institution, give street and numb Examiner If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Inthplece (State or Foreign Country) Funeral Deys Months Hours 10 M 20 F 223-18-1800 Director Usual Residence of Decedent with the Meryland 10d. inside City Limits 10c. City, Town or Location 10e. State 10b. County 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Ves 2 No BALTIMORE NIA Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3455 OTTAGE VENUE Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health end Mental Hygiene. Important: If Item 27 Is marked other than "naturel", or Item 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 if Yes, Give Year or Dates: Specify. by BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. KInd of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) SELF EMPLOYED WATERMAN LO TH GRADE NA 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UAVID TOSTER EDORA COSBY 19a. Informant's Name/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FOSTER BALTO. WIFE 3455 COTTAGE EVELYN MD. other 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Buriat 2 Cremation 3 Removal from State injury or 7-14-99 BALTO. MID 4 Donetion 5 Other (Specify) LION I EMESERY 22. Name end Address of Fecility VAUGHN C. GRE 21. Signature of Funeral Survino Licensee any is FUNERAL SERVICE GREENE XATL PIKE BALTO. MO. 5151 BAUTO. all ise, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory it. List only one cause on each line. 23a. Part1. Enter the dis-shock, or heart failu Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last and physician Box 68760 Physician/Medical the 88 esn for 23b. Did tobacco usa contribute to the cause of death? P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown signed by 1 Yes 2 No Division of Vital Records, by should be 24b. Were autopsy tindings evallable prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed has 2 No 2 No MACI funeral director, Be 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 22 No 2 1 Yes 2 ER/Outpatient 3 DOA Inpatient this 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending Naturel 5 Pending 2 🗌 No 1 Yes within 24 hours after death. To the Funerel Director: A 2 Accident investigation Location (Street and Number or Rural Route Number, City or Town, State) Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 3 4 - Homicide 8 Hospital 29e. Certifier The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and memor. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and memor stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical (Check only one) To the 29d. Date tigned (Month, Day, Year) 29b. Signature end title of cagifier nd address of person who completed cause of deeth (Item 23e) (Type, Print)
SERT TWILLAMS 5602 BAL I MORE NATIONAL DIKE 31. Dete filed (Month, Day, Year) Registrar's Signature 32. State 1 3 1999 Registrar



99-3920-510

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	State	of	Maryland /	Department	of Health	and Me	ental Hyg	giene 9

HELENA	
FLOWERS	

ed.	Physician /Medical
	Examiner

Funeral **Director**

Directo 28e-f ŏ 238 Funeral filed within 72 hours after Baltimore, Maryland 21215-0020 py Completed Hygiene. Be Pages 1 and 2 should be nent of Health and Mental 2 of Health in them 27 is r other tra = 5 Department of Important: If any injury or **Physician** /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed Box 68760. the phys 08n P.O. signed by the a Records, þ Completed has 96ad certificate of Vital Physician: Be funeral director, Certification: To this After Division or Attanding within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Hospital edicai 945

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev Year JULY 1999 3:15P.M. <u>Helena Regina Flowers</u> 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SHOCK TRAUMA CENTER CITY BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Days Months Hours 1□M 2□F 212 34 2894 1 - 20 - 38Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4747 Chatford Avenue 21206 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specity: White Specify: 3 ☐ Widowed 4 XD Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Rental Service Television Hostess TV Service Rental 12 years 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Helen Regina Maurer Robert Watson Green
19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Christopher R. Flowers (son) Baltiomore, MD 21206 7132 Willowdale Ave. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State 7-12-99 HOLY Redeemer Cemetery Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Neme and Address of Facility Dippel Funeral Home 7110 Belair Rd. Balto. MD 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fellure. List only one cause on each line. Approximate Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed' 2 □ No Yes 217 No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) XYes 2 No 1 ☑ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of tnjury 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injun 1 Neturel 1 ☐ Yes morcasso 2 Accident 3 ☐ Suicide Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City of Town, State) 6 Could not be determined 4 ☐ Homicide elso TIN 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only aned 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) and title of certifier O.C.M.E. JULY 8,1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

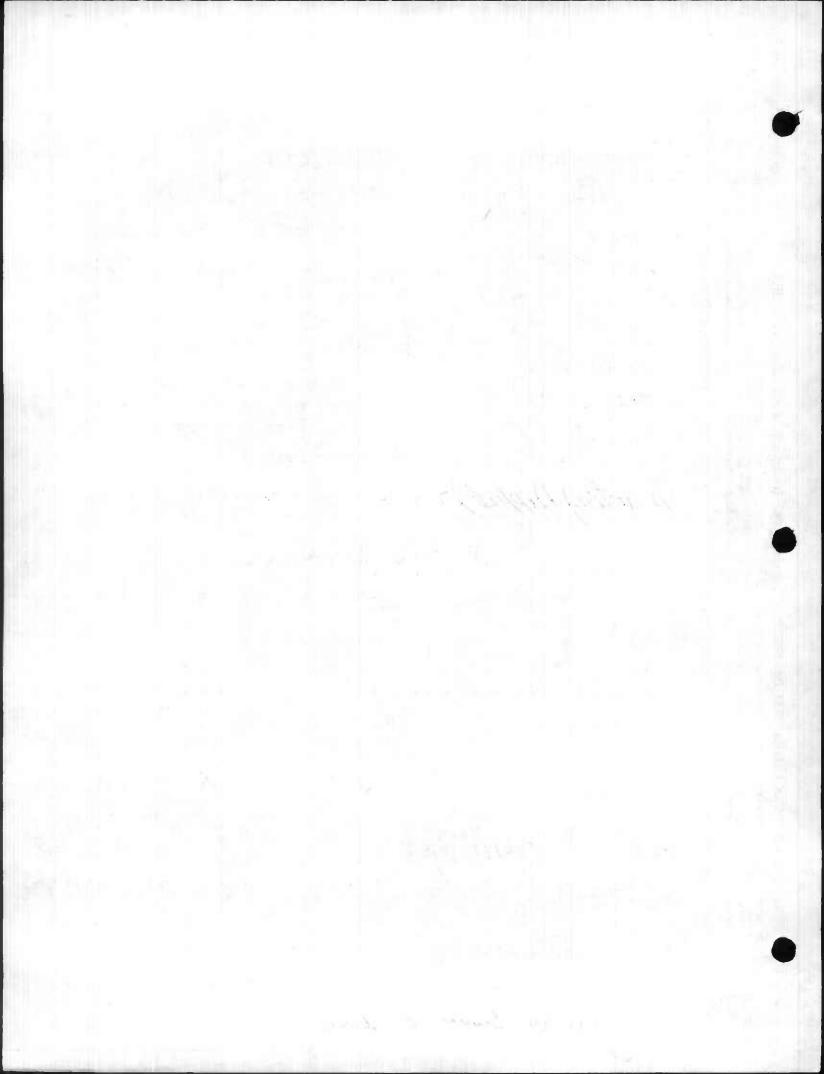
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32. Registrar's Signature

ORIGINAL

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Yeer **Physician** ame JUL DAYBO 9 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) Examiner Baltimore 8507 Westford Rd. Lutherville Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days 1⊠M 2□F Hours Yrs. Sept. 01 1944 Maryland Director 212-52-8514 54 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 ☐ No Director Lutherville MD. Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 USA 8507 Westford Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedant Evar in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 ☐ Married 1 Yes 2₺ No Specify: Specify: White py 3 ☐ Widowed 4 ☐ Divorced Yaar or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Disabled N/A marked other 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumama) permit. Peges 1 end 2 should be file Department of Health and Mental Hy Important: If them 27 ia marked other any Injury or other traumatic event Be Anna Kershner Thomas Leo Foglio 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Steta, Zip Coda) 8507 Westford Rd. Lutherville, MD. 21093 Mrs. Anna Foglio/Mother 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Cemetery 7-10-1999 Timonium, MD. 21. Signature of Euneral Service Lice 22. Name and Addrass of Facility Towson Funeral Home, York Rd. Towson, MD. Inc. 21204 Ruck 1050 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part1. Enter the di-Approximate Interval Between Onsat and Death Physician /Medical Immediate Cause (Final XIA diseasa or condition resulting in death) Examiner Due to (or as a consequence of): Examiner requires that the death certificate be executed end --Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): physician e Physician/Medical Dua to (or as a consequence of) for use as ed by the deteched Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Denknown signed b py 24b. Were autopsy findings available prior to should should 24a. Was an autopsy Completed complation of cause of death? The law s certificate has t director, page 2 s 1 Yas 2 No 1 ☐ Yes 2 ☐ No Physician: director, Be 25. Was case referred to medical 26. Plece of Deeth (Check only ona) Hospitel: Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) 2 1 9 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral 28d Describe hew injury occurred Gram

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28t. Location (Streat and Number or Rural Routa Number,
City or Town, State) 27. Manner of Death 28e. Date of Injury (Month, Law Year) 28b. Tima of 28c. Injury at Work? 12 ma of Injury of Certification: or Attending 1 Naturel 5 Pending 799 To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fu 8 1 Yes 2 LN death. Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At hor building etc. (Specify) At home, farm, atreet, factory, office 4 Homicide 8507 Westford Rd - Luthanille Home 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature artif title of certifier 29c License number racelest Dreselle 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Hamlet KIM

UTherville

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State Registrar 70 Mes F. O'l

JUL 1 3 1999

31. Date filed (Month, Day, Year)

ONNEIL MD

32. Registrar's Signature

DHMH 16 Rev 6/95

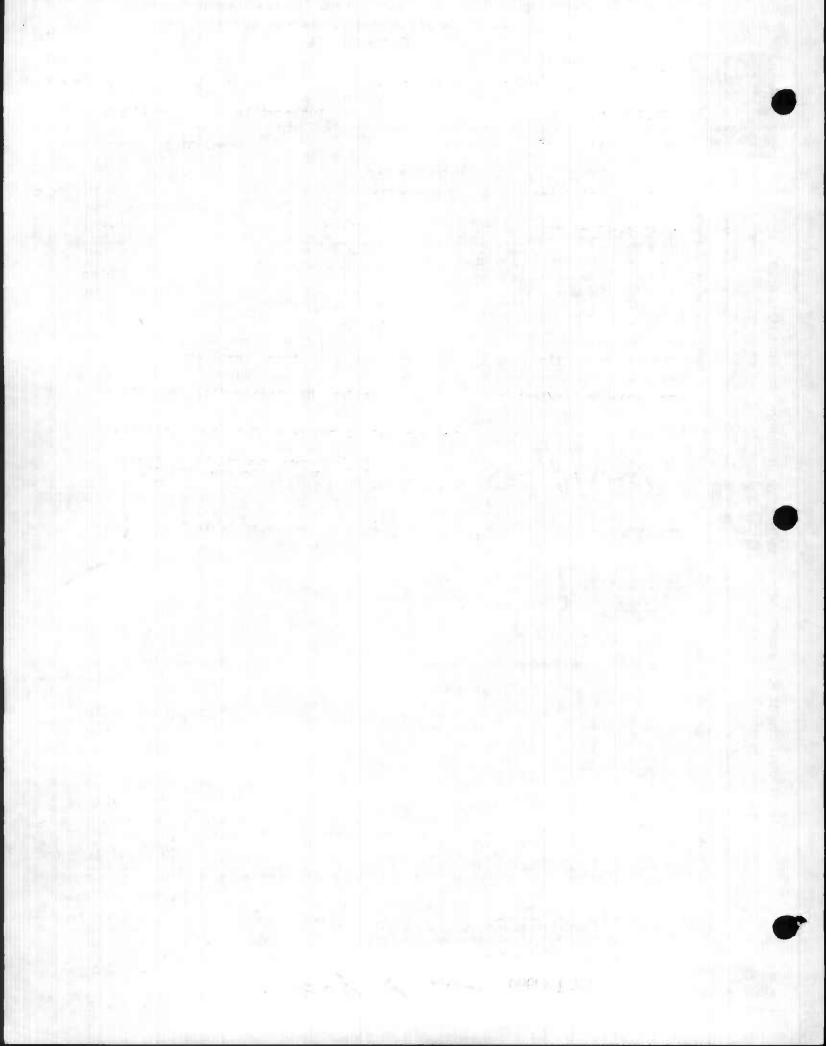
Maryland 21215-0020

aitimore,

Box 68760.

Records.

Division of Vital

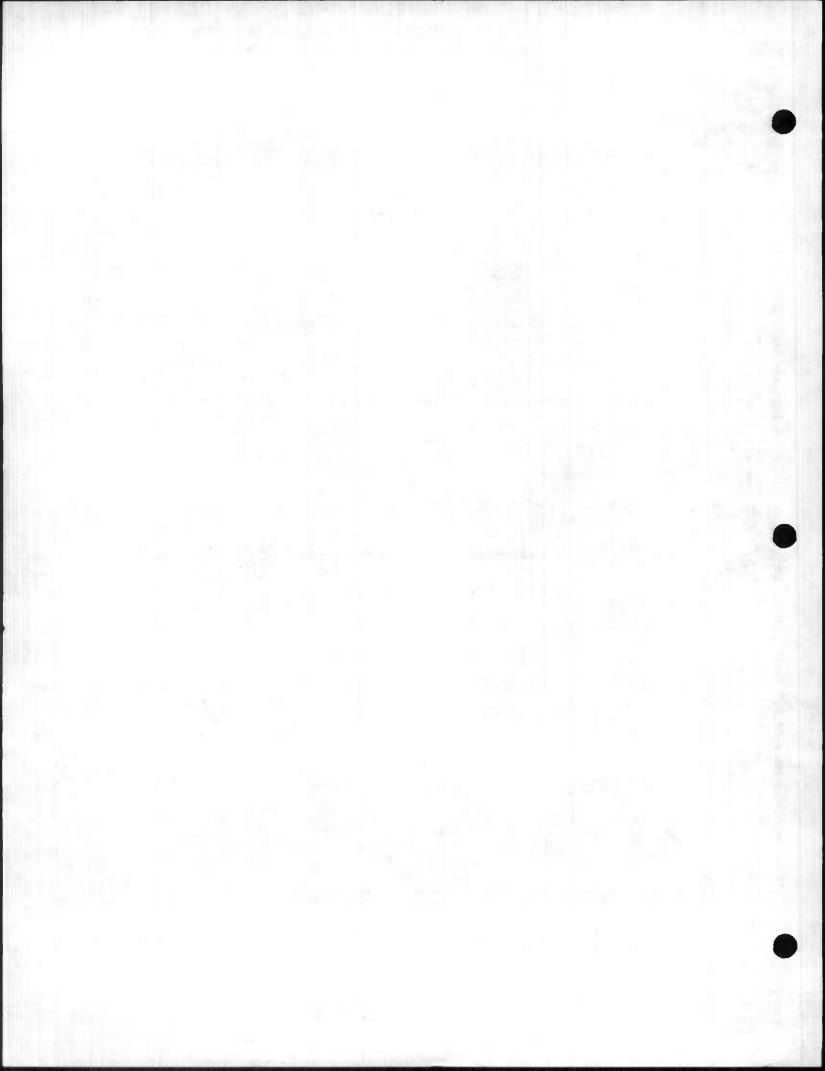


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** James Freeland Jr. 8, 9:00 PM July 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center N/A Baltimore Hours Min. B. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country)
 MD **Funeral** Days 12M 2□ F 62 Yrs 1936 219-32-3771 Director Usuat Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No MD N/A Directo Baltimore Name 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 S. Conkling St 21224 USA death.y Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. filed within 72 hours after 1 ☐ Yes 2 Ž No If Yes, Give Year or Dates: 1 Never Married 2 Married b altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Heating & Plumbing Plumber 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Pages 1 and 2 should be in ment of Health and Mental H ant: If them 27 is marked off lury or other traumatic even 8 James E. Freeland Sr. Vivian Hayes 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Freeland 1776 Brookview Rd /son Baltimore, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State July 1 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or ansa. 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Memorial Middle River, MD 22. Name and Address of Facility
Connelly Funeral Home of Dundalk 21. Signature of Funeral Service Licenses 7110 Sollers Point Rd 21222 onn MICKAM 23a. Part . Enter the disease, or complications that ceused the deathy shock, or heart failurer List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner OPI The law requires that the death certificeta be executed physicien and s the burlal-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Due to (or as a consequence of): 5minspe mig Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by to 2 No 3 Probably 4 Unknown by 24b. Were autopsy lindings available prior to completion of cause of deeth? le peed si 24a. Was an autopay performed? Completed has D800 2 certificata Division of Vital or Attending Physician: funaral director, 8 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) 30 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 30 DOA After this 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 5 Pending investigation NA deeth. t Yes 2 No e Hospital or Attendi n 24 hours ettar deeth e Funeral Director: / 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide filled in 29e. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical within 24 ho To the Fune completely f (Check only one) 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 0024302 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mukesh Luhar, M.D. 3509 Eastern Ave Baltimore, MD 31. Date filed (Month, Day, Year) 3 1999 32. Registrar's Signature State Registrar

AH



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CI	HERYL GRE	EN	State of Mai	•	epartm <i>Certific</i>				giene g	9 2	1884
		1. Decedent's Name (First, Middle, Las	st)					2. Date of De	ath		Time of Death
	Physician /Medical	CHERYL D	GREEN					JULY	8, 1999	Year	0230 AM
	Examiner	4e Facility Name (If not Institution, give 2625 MILES AVET					4b. City, Town, or La BALTIMOR		4c. County		
	Funeral Director	5. Social Security Number 21 2 82 6598 1	ex	(In yrs. last birtl	hday) If U Mon	nder 1 Year ths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir FEB. 6	7.1961	9. Birthplace MARYL	(State or Foreign
	2 .	Usual Residence of Decedent 10a. State 10b. County		IOc. City, Town	or Lagation					104.1	Inside City Limits
	or 28a-1 show or 28a-1 show on notified at Director	MD N/A		BALTI							Yes 2 No
	or 28ad a be notified Director	10e. Street and Number		DALLI		. Zip Code			10g. Citizen of \	What Country?	, s
		2625 MILES	AVENUE			21211			U.S.		
0	or Name 23a miner must Funeral	11. Merital Status 1 Never Married 2 Married	12. Was Decedent Ev Armed Forces? 1 Yes 2 No	er In U,S.	13. Was D If Yes,	ecedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Rad Blad	e - American II ck, White, etc.	ndian,
9	72 hours after natural", or its fical Examina sted by Fu	3 ☐ Widowed 4 ☐ Divorced	If Yas, Give Yeer or Dates:		1016	200,00	Specify:		Specify	^{/:} B1	LACK
4	72 h natu	15. Decedent's Ed (Specify only highest gre-	ucetion de completed)		Decedent's (Give kind o	f work done	during most of work	ing	16b. Kind of B	usin eas/I ndustr	у
21215-0020	be filed within 72 ho tal Hygiene. d other than "natur event, the Medical. Be Completed		College (1-4or 5+) UNKNOWN		FOOD		VICE PRO			NG HO	ME
Maryland	STOR OF	17. Father's Name (First, Middle, Last)					18. Mother's Nam			10)	
2	d Men d Men marks marks	MARSHALL LEON (10h	Melling Add	Irace /Strage	MACON t and Number or Rui			State 7in Con	(a)
Ma	and 2 a nuth an 127 is er frau	MACON L. CURTIS					LANE A				
altimore,	A House	20a. Method of Disposition		20h Place of	Disposition	(Name of		Date	20c. Location		
Ë	Page int: if	1 A Buriai 2 Cremation 3 4 Donation 5 Other (Specify		MT. Z	ZION	CEME	ren 7/1	5/99	BALTIM	ORE, MA	ARYLAND
Balt	Departi Departi Importa any inju	21. Signature of Fineral Service Licen	THEWIS	. GWYN	N L	EWIST	ess of Facility C. GWYNN				
		23a. Pert1. Enter the disease, or companies shock, or heart failure. List only of	olications that caused	leath. Do no	ot enter the	51/ mode of dyi	PARK HEI ing, such es cardiac	GHTS A or respiratory a	VE. E	ALTO.	. MD . proximate ervel Between
	Physician	shock, or heart failure. List only o	one cause on each line	1.						On	set and Death
	/Medical	Immediate Causa (Final disease or condition	tath	twee							
	Examiner	resulting in death)	В	ue to (or as a c	onsequence	of):				1	
	od nine		b							į	
	executed an and riel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Di	ue to (or as a co	onsequence	of):				Ì	
8760,	cate be executed the burlat-transit dical Examir	Cause. Enter Underlying Cause (Disease or injury that initiated events	c	ue to (or as a co	200000000	of).				1	
9	= = 0	reaulting in death) Last	Di	ie to (or as a co	msequence	orj.				İ	
Box	attending p for use as		d					The state of			
o.	res that the death certificated by the attending to be detached for use a by Physician/M	Part II. Other significant conditions co	ontributing to death but	not resulting in	the underlyi	ng cause gi	ven in Part I.	23b. Did	tobacco uss co	ntributs to the	causs of death?
J.	that the ded by deta							10	Yes 2 No	3 Probabl	y 4 Unknow
Hecords,	been should								an autopsy rmed?	eveilab	sutopsy findings ble prior to tion of cause
Ř	has ge 2							100	CIN	of deat	
Vital	ficate h	25. Was case referred to medical		-			OC Disease Danie	- X	Yea 2 No	/V°	s 2 No
	Physician: The la r this certificate has sral director, page 2 r. To Be Comp	evaminer?	Hospital:	2 ER/Out	nationt 3	DOA Ot	26. Place of Deal		dence 6 Oth	ner (Specify)	
100	g Phy er thic neral c	27. Manner of Death	28a. Dete of Injury (Month, Dey	28b. Ti	me of	28c. Inju			how injury occur		
DIVISION	as or Attending P rs after death. In Director: After t ed in by the funer: Certification:	1 Natural 5 Pending Investigation 3 Suicide 6 Could not be			jury M m. street fa	1	Yes 2 No	28f. Location /	Street and Numi	ber or Rural Ro	ute Number.
2	sher de Att Direct d'in by de la by	4 Homicide determined	building, etc.	(Specify)	, əнөөң Id	otory, omce		City or To	vn, Stete)		
	24 hours 24 hours Funeral etely filled dical Ce		rsician: To the best of								
	P Fu	(Check only one) CXMedical Exam	itner: On the basia of ea and manner state		or investiga	ition, in my	opinion, death occur	red et the time,	date end place,	and due to the	cause(s)

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

State

Registrar

29b. Signeture and title of certified

111 Penn Street, Baltimore, Maryland 21201

THE ONONE U. King 1111
31. Date filed (Month, Dey, Year) 32. Registrar's Signature 1 3 1999 JUL

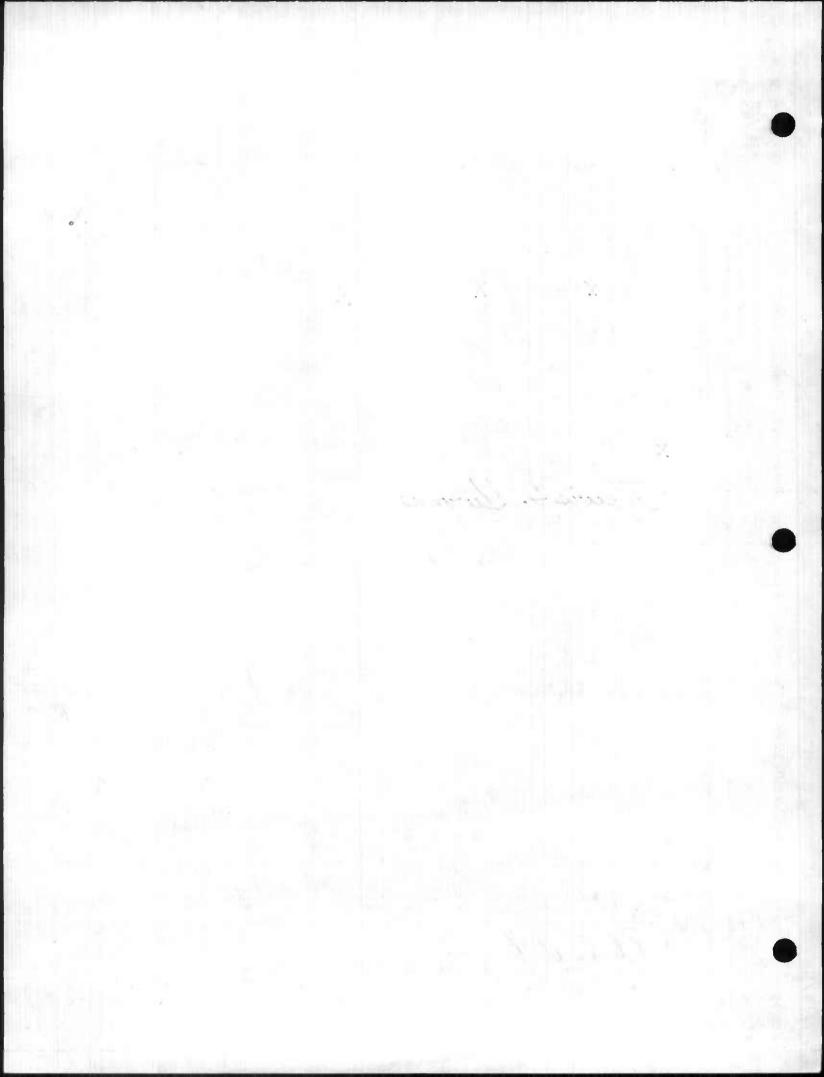
DHMH 16 Rev 6/95

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

JULY 8, 1999



imposs Holo Rd Severna Park

Registrar

DHMH 16 Rev 6/95

State

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

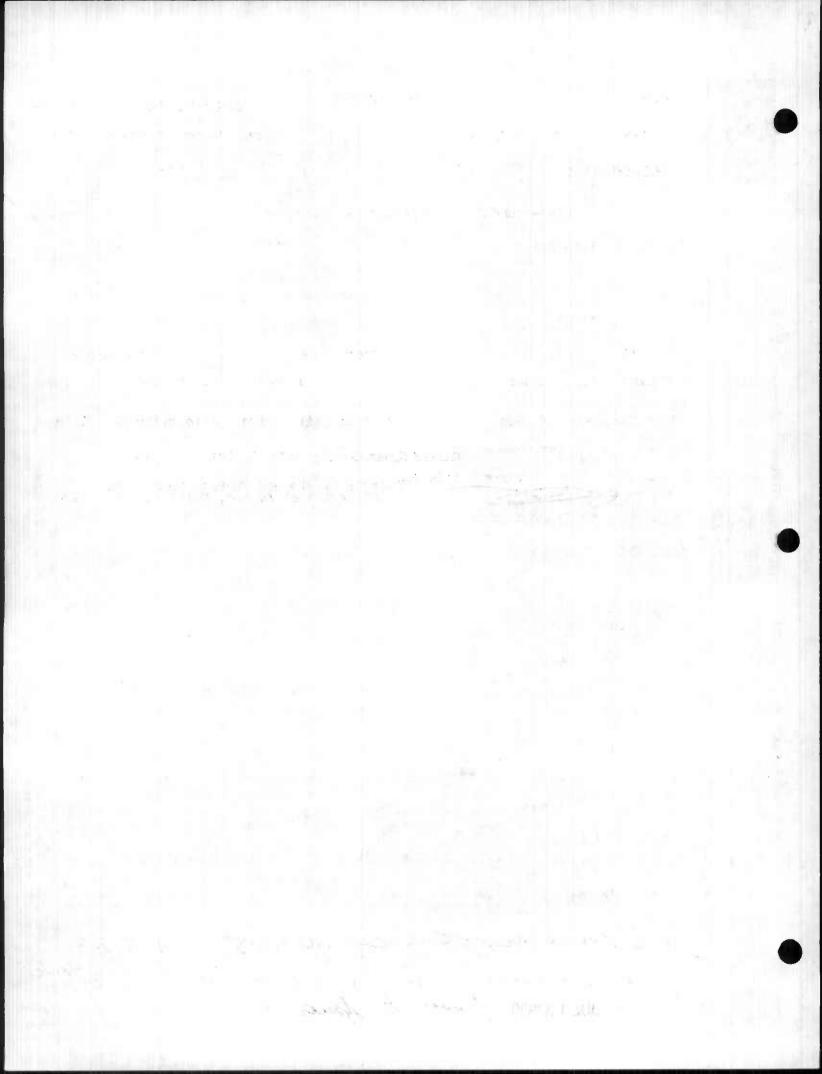
ebecca Elon MD

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32. Registrar's Signature

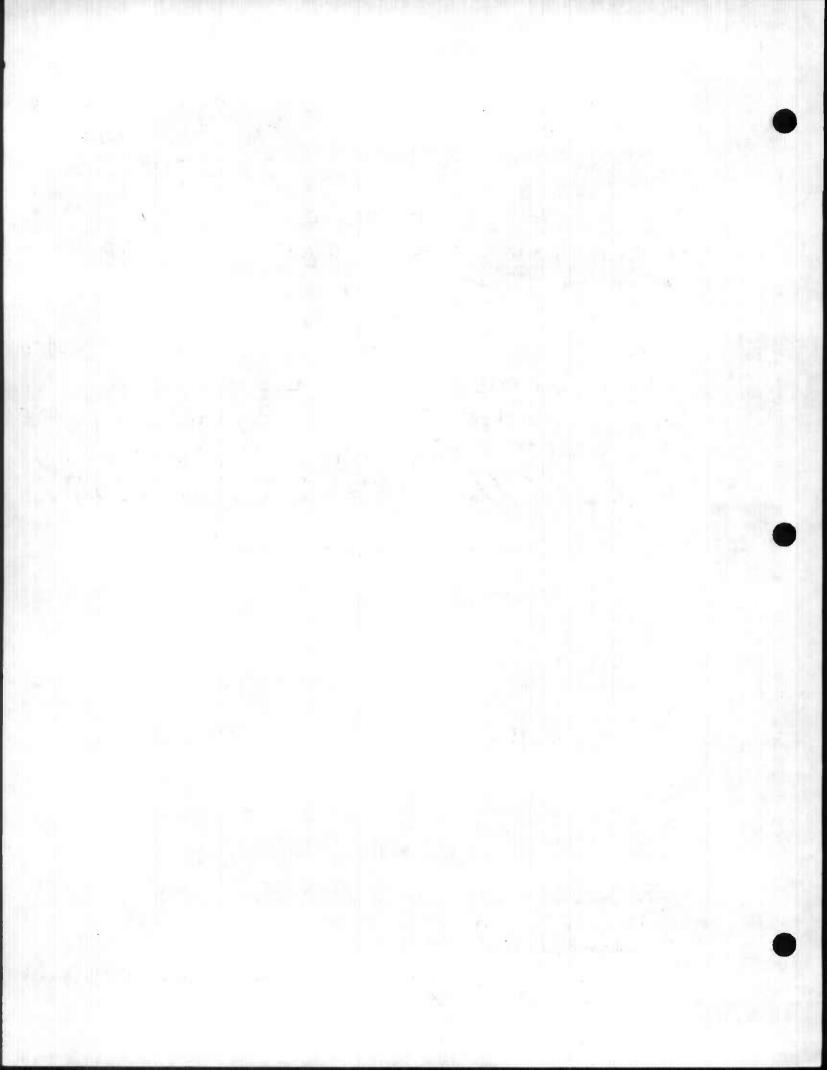


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B.K.S	State of Maryland / Department of Heavis Certificate of Department			21886
SARAH GIVE	1. Decedant's Nama (First, Middla, Last)		Reg. No.	3. Time of Death
Physician	Sarah Givens		onth Day Y JLY 4, 1999	11:00 AM
/Medical Examiner		City, Town, or Location		
Examiner	925 NORTH BROADWAY #102	BALTIMORE		NIA
Funeral	Months Days	H Under 24 Hrs. 8. Da Hours Min. (Mo	ta of Birth onth, Day, Year)	Birthplaca (State or Foreign Country)
Director	241-50-3294 69 TS.	m	rch 5,1935	"5C
pu &	Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location			10d. Insida City Limits
f sho	mo silo Dili	0		1 Yas 2 No
with the Mai t or 284-1 s be notified Director	10e. Street and Number 10f. Zip Code		10g. Citizen of Wh	at Country?
38 o al	925 North Broadway #102 218	305	(19	SA
5-0020 72 hours after death with the Maryland natural, or Items 23a or 28a-1 show area Examiner must be notified at steed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forcas? 13. Was Decedent of Hisp If Yas, specify Cuben, I		as or No-	American Indian, White, etc.
or he or he	1 Nevar Married 2 Married 1 Yas 2 Mo	Specify:	Specify:	vinite, etc.
DOOZ DOUIS &	3 Widowed 4 Divorced Yaar or Datas:			Black
	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during the completed)	ion ring most of working	16b. Kind of Busin	ness/Industry
T 3855 5	Elementary/Secondary (0-12) College (1-4or 5+)		Scho	al Sustem
other other	17. Father's Nama (First, Middla, Last)	8. Mother's Name (First,	Middle, Meiden Sumama)	101 293101
yland yland Mental H mrked off	Carry Carrens	1	Cake	~
E SEE	19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and	d Number or Rural Rout	a Number, City or Town, St	ete, Zip Code)
e, Marand 2 Health a pm 27 la ther tra	Carla B. Carlest-Lee 7506 Biscay	Ine Bay	BIVDchas	offic dm. so
OT He The The The The The The The The The Th	20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place)	- Oate	20c. Location - Ci	ty or Town, Stata
altimor nlt. Pages artment of ortant: If he injury or o	1 Burial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify)	7/13	199 Randalls	town mD
Baltimore permit. Pages 1: Department of He important: if Nem any Injury or oth pages.	21. Signature of Frincial Service Licensee 22. Nama and Addrass	of Facility	inval Ham	e P.A
m 89F#8	Seneral A. hand 270 Freshi	Hon Pass	Ralto, m	0 21229
	23a. Fairt. Ever the disease, or complications that caused the death. Do not enter the mode of dying, shock or heart failure. List only one cause on each line.	such as cardiac or respi	iratory arrest,	Approximate Intervat Between
Physician				Onset and Death
/Medical Examiner	Immediata Causa (Finat disaasa or condition rasulting in death) Arteriosclerotic Cardiovascu rasulting in death)	ular Diseas	se	i I
	Dua to (or as a consequence of):			
oxecuted n and ial-transit	b			•
760, be executed stelan and burial-transit	Sequentially list conditions, if any, teeding to immediate causa. Enter Underlying			1
760 sicia sicia bur	Cause (Disease or Injury that initiated events Due to (or as a consequence of):			
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P.O. Box 68 Let the death certificate by the attending phetached for use as the physician/Med	d			I
. 0 0 2	Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given	in Part I. 2	3b. Did tobacco use contr	ibute to the cause of death?
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bed by	O poes			
The law requires trate has been signe, page 2 should be.	Violetes hellitus		performed?	24b. Were autopsy findings available prior to completion of cause
Rec e law has b	100	I	NSPECTION	of death?
= F # & 0			1 ☐ Yes 2XXNo	1 Yes 2 No
Of Vital Physician: The Physician: The contricate ral director, page 1: To Be Co	axaminar?	26. Placa of Death (Che	ck only ona)	
는 하는 가	XX Tas 2 I No 1 Inpatient 2 EH/Outpatient 3 I DOA	4 U Nursing Home 5	Residence 6 Other escribe how injury occurred	
Sion o leath. or: After th the funeral	XXNaturet 5 Pending (Month, Day Year) tnjury Work?	es 2 No	oscioo non agary occurren	
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papitu hours mera ly fille	29a. Certifier 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time,	, date and place, and du	e to the cause(s) end menr	er as stated.
DIVIS To the Hospital or Attention 24 hours after de To the Funeral Directo completely filled in by the Medical Certific	(Check only Medical Examiner: On the besis of axamination and/or invastigation, in my opini and manner stated.	nion, death occurred at t	ne ilma, data and place, an	o oue to the cause(s)
To the Common	29b. Signature and title of certifier 29c. License n		29d. Data signed (
	O.C.N	M. E	JULY	12, 1999
3	30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)			
	J. Laron Locke M.D. 111 Penn Street, E	Baltimore,	Maryland 212	01
State Registrar	31. Data filed (Month, Day, Year) 532. Registrar's Signature			

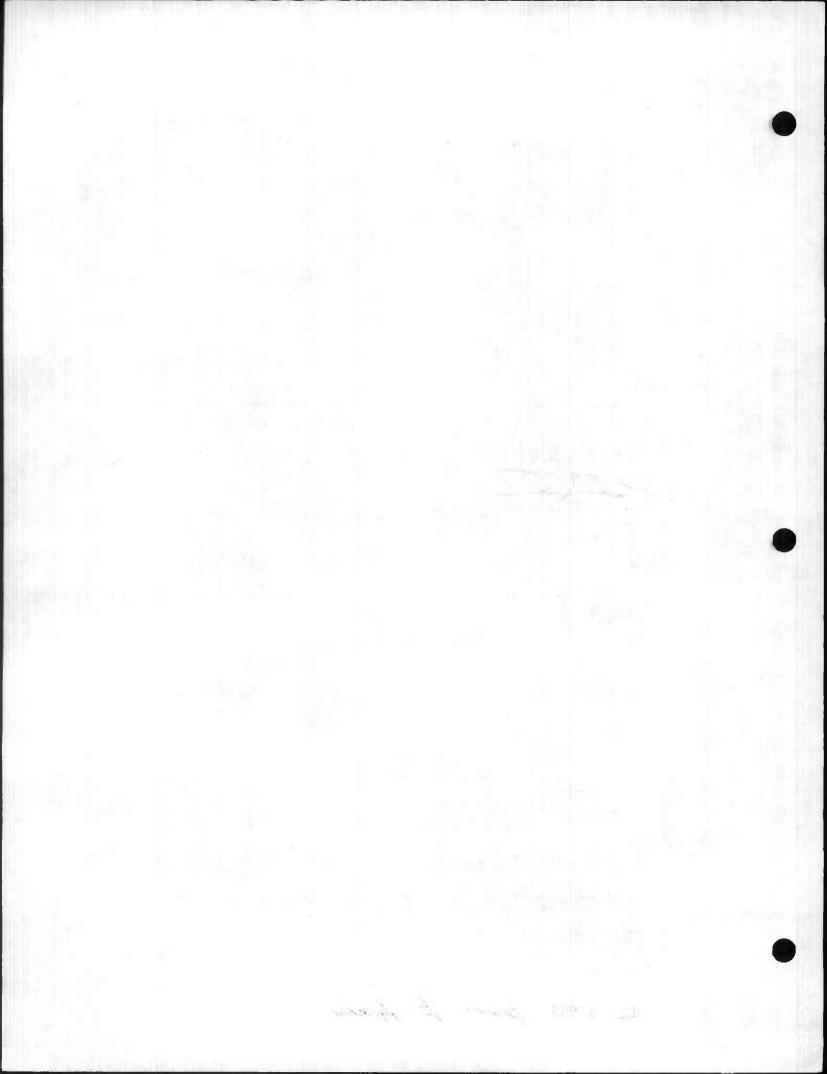
DHMH 16 Rev 6/95

ORIGINAL



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	State of Mary		tificate of			Reg. No.	21007
Physiciar	Decedent's Name (First, Middle, Last)				2. Dete of De Month	Day Y	3. Time of Death
/Medica	Verna M.	G	Glisson		July	11, 199	
Examine	4a Facility Name (If not institution, give street and number)			lb. City, Town, or Lo	ocation of Death	4c. County of	Death
	Pickersgill Retirement Ho			Towso			ltimore
Funeral Director	147-05-8055 1□ M 2ÅF	n yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da July 4,	v. Year)	New Jersey
ahow dan		Oc. City, Town or Lo	cation	5			10d. Inside City Limits
N THE	MD Baltimore	Towson					TILITES ZEJNO
# 5 8 E	10e. Street and Number		10f. Zip Code			10g. Citizen of Who	at Country?
23 m	615 Chestnut Ave.			21204		USA	
5-UUZU 72 hours after death with the Meryland natural; or items 23a or 28a-f show dical Examiner must be notified at	11. Marital Status 1 Never Married 2 Merried 1 Never Married 2 Merried 1 Yes 2 No If Yes, Give Year or Detes:		Was Decedent of H f Yes, specify Cubi I ☐ Yes 2 ☐ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		American Indien, Whita, etc. White
72 hours	15. Decedent's Education	16a. Deced	ient's Usual Occup	ation		16b. Kind of Busin	ness/Industry
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G 2121 fled within Hyglene. ther then ent, to the	Elementary/Secondary (0-12) College (1-4or 5+) N/A		Homemak				Own Home
D HE CO	17. Father's Name (First, Middle, Last)	1			e (First, Middle,	Maiden Sumame)	
centifimore, Maryland 21215-0020 centif. Peges 1 and 2 should be filed within 72 hours at constraint of Health and Mental hygiene. reportant if item 27 is marked other than "natural", or my injury or other treumatic event, as its direct from	David McDowell			Est	ella Ma	dison	
Sah Sah	19a. Informant's Neme/Reletionship (Type, Print)	19b. Meilin	ng Address (Street	and Number or Run	al Route Numb	er, City or Town, St.	ate, Zip Code)
1 and 1 Health Health Wher tr	Lynn E. Glisson/Son	1208	Woodland	Ct. Hamp	stead,	MD 21074	
Peges 1 annant of Healt	. Kara a Da	20b. Place of Disposers cemetery, crem Bethel Pr	netary or other plea	æ) 20	uly 14	20c. Location - Ci	ty or Town, Stete
INTERPRETATION OF THE PROPERTY		Church Ce	metery	an	1999	White	Hall, MD
Baltim Department Important: Pag angs.	21. Signature of Funantial Private Library Michael J. Flagle	Le		ss of Fecility eral Home nia Road			
	23a. Part1. Enter the disease, or complications that caused the shock, or heart feiture. List only one cause on each line.						Approximete Interval Between
Physician /Medical							Onset and Deeth
Examiner	Immediate Cause (Final disease or condition resulting in death)	010/00000000000000000000000000000000000	177 / E	9 003	202		- Junis
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d de d	Part II. Other significant conditions contributing to death but no	ot resulting in the ur	nderlying ceuse giv	en in Pert I.	23b. Did	tobacco use contr	ibute to the cause of death?
requires that the death certification is a signed by the estending hould be detected for use as	Diabetes melli	itus			10	Yes 20 No 3	Probably 4 Unknown
8 8 8 8						an autopsy rmed?	24b. Were autopsy findings available prior to completion of cause of death?
					10	res 2000	1 ☐ Yes 2 ☐ No
yaiclan: The is secreticate he director, page	25. Was case referred to medical			26. Place of Deet	h (Check only		
hysicis on i direct	examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ☐ ER/Outpatien	t 3 DOA Oth	07-		dence 6 Other	(Specify)
or Attending Physician: T after deeth. Director: After this certificat din by the funeral director, p	27. Manner of Death 1 SNatural 5 Pending (Month, Day Ye	28b. Time of	28c. Injur Wor	y at k?		how injury occurred	
the first	2 Accident investigation 3 Suicide 6 Could not be			Yes 2□No			
be or Attending P as the death. In after deeth. In Director: After the funeral of in by the funeral control of t	4 Homicide determined 28e. Place of Injury building, etc. (S	- At home, ferm, stre Specify)	eel, fectory, office		28f. Location (: City or To		or Rural Route Number,
To the Hospital or Attending Phy within 24 hours after deeth. To the Funerel Director, After thi completely filled in by the funeral Madinal Cartification.	29a. Certifier (Check only one) 1 Certifying Physician: To the best of m (Check only one) 2 Medical Examiner: On the basis of examiner and manner steled	aminetion end/or inv					
Vithin omp	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signed (Month, Day, Year)
- > - 0	DO D. M D. V.	i mo	0.2	2063,		7.1.1.	1999
	30. Name and address of person who completed cause of death	Iltern 23a) (Type	Print)	3 203		Jucy 12	1111
	W. A. R. ley UGBMO	6701 Signatured	N. Cha	rles St.	Ba	lto, ind	2,1999 1 21203
State Registrar	31. Date filed (Month, Day, Year) JUL 1 3 1999 32. Registrar's	Ø. A	Sparks				



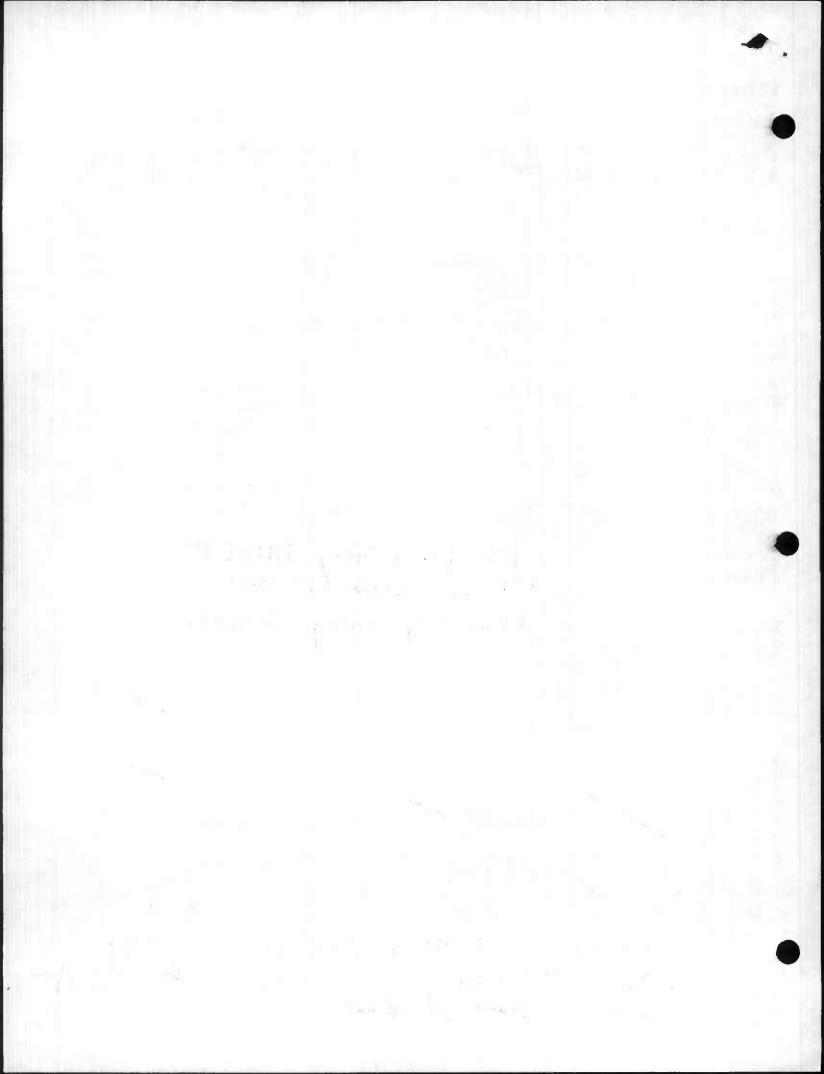
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 4:45 pm **Physician** Month GLADDEN MARGIE m. 07 99 06 /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BON SECOURS SAUTMORE
If Under 24 Hrs. 8. De NA OSPITAL 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 10 M 20 F 577-42-8042 10 Yrs. Director Usual Residence of Decedent 10e State 10b County 10c. City, Town or Location 10d. Inside City Ltmits 28a-f show Example: mast be notified 1 Yes 2 No Director BALTIMORE mo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of Whet Country? 6 2529 ітетв 23в LOMBARO OTREET Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritel Status filed within 72 hours efter 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: by 3 Widowed 4 □ Divorced BLACK Completed 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) HOME 12 TH GRADE OMESTIC 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be file Department of Haaith and Mental Hy Important: if item 27 is marked other any injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Sumame) LILLA BARBER GENERAL O. W. MALONEY 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 2529 BAUTO. . LOMBARD MD. 21223 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Buriat 2 ☐ Cremetion 3 ☐ Removal from State KLEASANT GROVE CEMETERY 7-13-99 GREAT FAUS 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility VAUGHN C. GREENE FUNERAL SERVICE or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. BAUD. MD 21229 23a. Part1. Enter the d Approximate Intervat Between Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentially tist conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): P.O. Box 68760, the Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed d be dat Records, þ cate has been sig. Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 2 PNo 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 0 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 5 Pending investigation 1 Natural death. 1 Yes 2 Accident To the Hospital or Attend within 24 hours after deal To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) in by 4 Homicide filled 1(Uertifying Physicfan: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.
2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end manner stated. edical 29a. Certifier completaly 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

32. Registrer's Signature

S T DHM

DHMH 16 Rev 6/95

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth 9 Dey JULY 1999 FLORENCE HIGGINS \mathbf{E} 2:06 am 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth FRANKLIN WOODS NURSING HOME ROSEDALE BALTIMORE 5 Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year June 21 1905 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Months Days 1 ☐ M 2√2 F 215-52-0950 94 Yrs. Usuel Residence of Decadent 10e State 10b County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Essex 1 ☐ Yes 2 No 10e, Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7209 Golden Ring Road 21221 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: Race - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🏖 ☐ No Specify: White 3 Widowed 4 Divorced 15. Decadent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8th own home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Jacob Wise Vera Killian 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Carole Horst / daughter 7209 Golden Ring Road Baltimore Md. 21221 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Moreland Memorial 7/12/99 Baltimore Md. 21. Signeture of Funeral Servica Licensee 22. Name end Address of Fecility Connelly Funeral Home of Essex 23a. Pert1. Enter the disease, or complications that caused the death of not enter the mode of dying, such es cardiac or respiretory errest, shock, or heer feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Death Immediate Cause (Final diseese or condition resulting in death) rebro balen Due to (or es e consequence of): Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy pollyvordism completion of cause of deeth? 1 ☐ Yes 2 ☐ No

Examiner The law requires that the death certificate be executed the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Physician/Medicai for use as

by

Completed

Be

Certification: To

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page 2 should be

certificate

this funeral

After

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show

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'natural',

I Hygiene.

.. Pages 1 and 2 should be filed w tment of Health and Mental Hygier tant: If Item 27 Is markad other th jury or other traumatic event, the

Department o important: If any injury or

Physician /Medical

Examiner

the Medical Examiner

Director

Funeral

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Completed

Be

the Maryland

with

filed within 72 hours after death

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Records,

Division of Vital

Hospital or Attending Physician:

To the

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

GASTRIC LYMPHOMA 25. Wes case referred to medical

exeminer'

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 28b. Time of

Other: Nursing Home 5 - Residence 6 - Other (Specify) 28d. Describe how Injury occurred

26. Plece of Deeth (Check only one)

exeminer?

1 Yes 2 No

Manner of Deeth

Naturel 5

2 Accident 3 Suicide

4 Homicide

5 Pending Investigation 6 ☐ Could not be determined

28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

29a. Certifier

Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) end manner es steted.

Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) and menner steted.

29b. Signeture end title of central

29c. License number 8326 29d. Dete signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

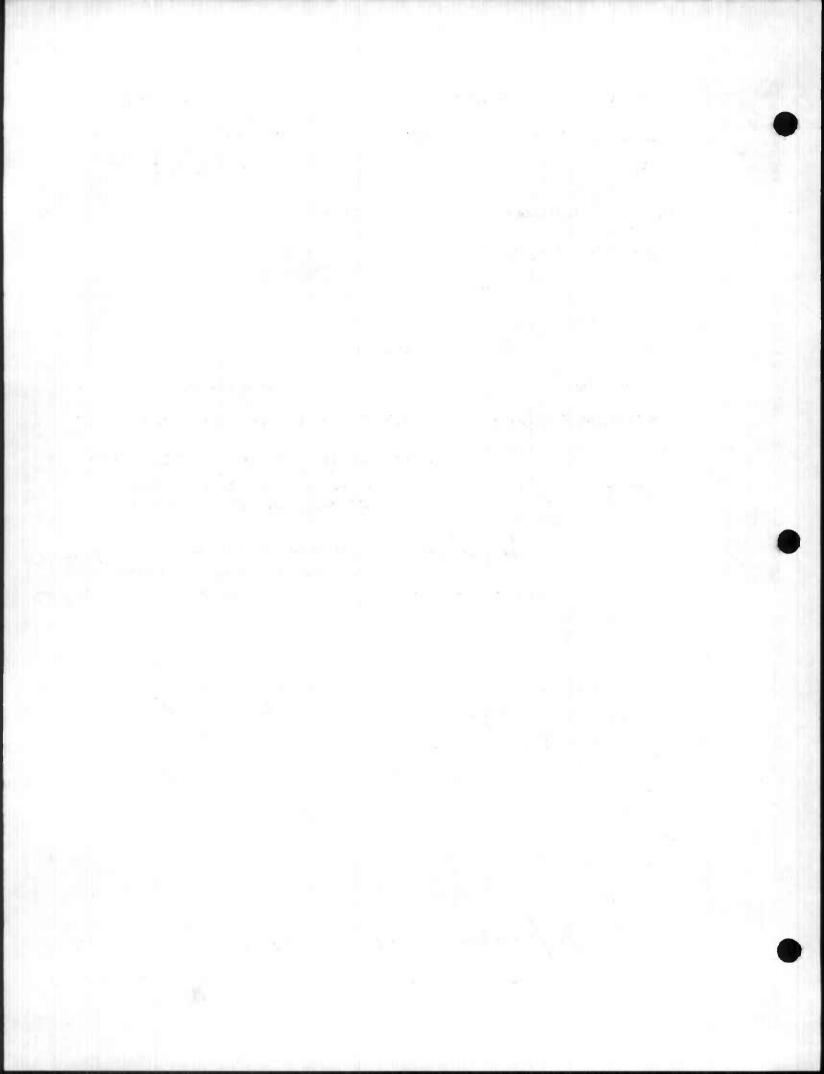
30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

predic GAUHAR NASEM ESSEX

Cofr. Balt-MD 2/22/

State Registrar

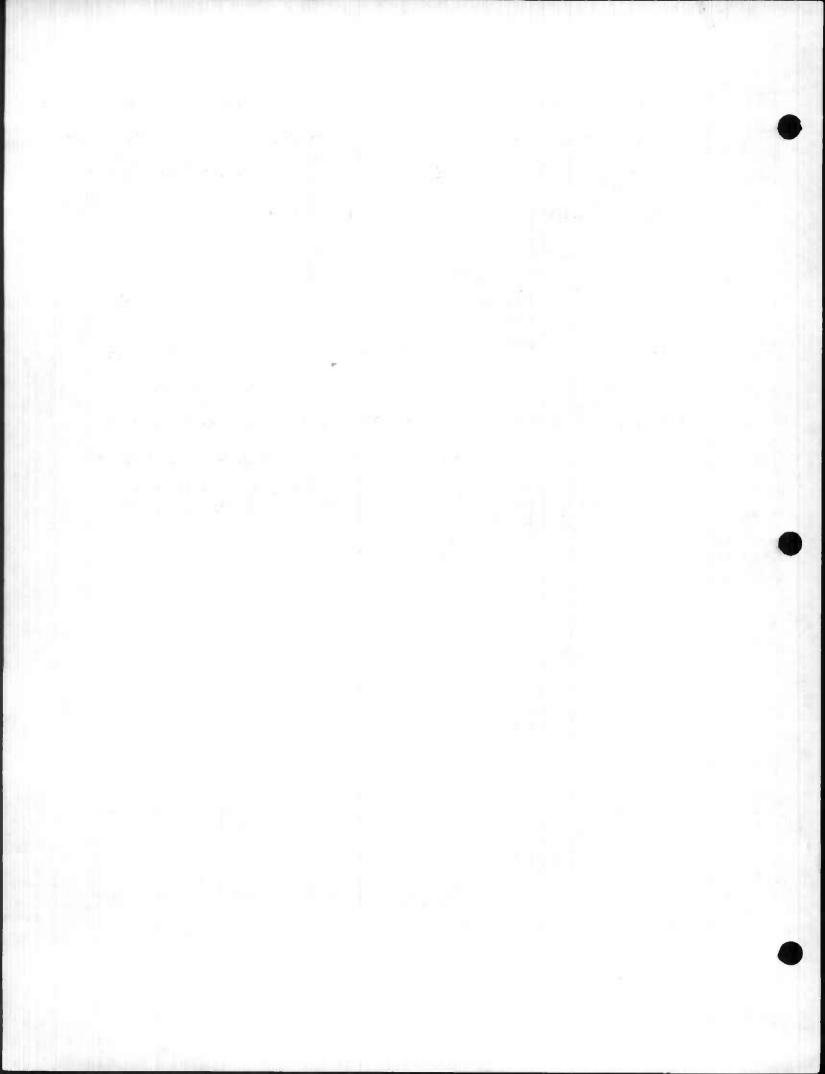
31. Date filed (Month, Day, Year) JUL 1 3 1999 32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

						Cei	rtificate c	of Death	7		Reg. No.		
	Disserted		1. Decedent's Name (First, Middle,	Last)						2. Date of Dea	ath	Veer	3. Time of Death
	Physic /Medi		EDWARD HA	ARR						JULY	⁹ 1	9899	2:45pm
	Exami		4a. Facility Name (If not institution,							ocation of Death	4c. County	of Death	
L			6618 Ebenez	zer Road						River		Balt	imore
	Funeral Director		224-12-7518	3. Sex 7. Ag	e (In yrs. lest bi	rthdey) Yrs.	If Under 1 Ye Months Da		r 24 Hrs. Min.	8. Date of Birt (Month, De Oct • 24	1916	9. Birthp Coun Kent	
	and *		Usual Residenca of Decedent 10a. State 10b. County		10c. City, Tow	vn or Lo	cation		_			1	IOd. Inside City Limits
	Sa-f sho	Director		timore			Mid	dle Ri	ver				1 ☐ Yes 2 🔀 No
	23a or 2		10e. Street and Number 6618 Ebenezer	Road			10f. Zip Cod	° 21220			10g. Citizen of US		itry?
020	ges 1 and 2 should be filed within 72 hours effer death with the Maryland it of Health end Mentel Hygiene. If item 27 is marked other than "naturel", or items 23a or 28a-f show or other traumetic event, the Medical Examinat must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		1 7	Was Decedent of Yes, specify C	uban, Mexica	an, Puerto	pecify Yes or No- p Rican, etc.)	Bia	ce - Americ ick, White, by: Whi	etc.
5-0	72 ho natur	sted	15. Decedent's (Specify only highest		16a	. Dece	dent's Usual Oc kind of work do	cupation	st of wor	kina	16b. Kind of B	usiness/in	dustry
Maryland 21215-0020	d within giene. r than "	Completed	Elementary/Secondary (0-12) 7th	College (1-4or !	5+)	iife. I	<i>nor</i> use re rner	tired)	31 07 1107	, , , , , , , , , , , , , , , , , , ,	Beth	Stee	1
b	e filed el Hygie other	BeC	17. Father's Name (First, Middle, La	ist)				18. Moth	ner's Nan	ne (First, Middie,	Meiden Sumer	ne)	
<u>la</u>	should be and Mentel marked o	TOE	Zim Harr						R	oslie (Charles		
ar	12 should be n end Mentel 1s marked raumetic ev		19a. Informant's Neme/Relationshi		198	b. Mailir	ng Address (Str	eet end Numi		ral Route Numbe			•
	of Health of Health Item 27 I		Elizabeth Surgu	y /friend			8 Ebene		ad	Baltimo	re Md.	21220	
Baltimore,	permit. Pages 1 Department of H Important: If iter eny Injury or ott		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		cemete	ry, crer	sition (Name of matory or other 11 Ceme	place)	7/	Date 12/99	20c. Location Baltin		
<u>=</u>	orta		21. Signature of Funeral Service Lie				. Name and Ad						
m	Depariment of the part of the		23a. Part 1. Enter the disease, or o	10	0/1					al Home			
68760,	Physician /Medicale pe oxaminer be physician end be physician end be see the pruiei-transit	edical Examiner	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that Initiated events	b	Due to (or as a	consec	quenca of):						
Box 68	ing e	∑	resulting In death) Last	d									
P.O. E	t the d by the	Physician/	Part II. Other significant conditions	s contributing to death b	ut nol resulting	In the u	nderlying cause	given in Pari	II.		tobacco use co Yes 2□ No	ontribute to	o the cause of death?
Records,	law requires has been sign ge 2 should be	Completed by									en eutopsy med?	co of	rere autopsy findings railable prior to mpletion of cause death?
ita	dcian: The certificate irector, pag	Be (25. Was case referred to medical examiner?					26. Plac	e of Dea	th (Check only o	ne)		
n of Vital	ng Physician: ter this certific nerel director,	ို	1 ☐ Yes 2 No 27. Manner of Deeth 1 Natural 5 ☐ Pending	Hospital: 1 Inpatie 28a. Dete of Inju (Month, De	ry 28b.	utpatier Time of Injury		Other: 4 Nork?	lursing H	ome 5 Resid	denca 6 🗆 Otl now Injury occu		ý)
Division	To the Mospital or Attending Ph within 24 hours effer death. To the Funeral Director: Affer thi completely filled in by the funeral	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be as Blace of In-	ury - At home, for a control of the	arm, str		I □ Yes 2 □] No	28f. Location (S City or Tox		ber or Ruri	al Route Number,
	To the Hospital within 24 hours (To the Funeral I completely filled	edical Co	29a. Certifier 12 Certifying (Check only one) 2 Madical Ex	Physician: To the best aminar: On the basis of	examinetion at	e death	n occurred et Ih	e time, date e ny opinion, de	nd place	, end due to the rred et the time,	cause(s) end m dete end place,	anner as s	itated. o lhe ceuse(s)
	ithin i	Med	29b. Signature and title of certifier	and manner st	100		29c. Lic	ense number			Date slone	ad (Month.	Dey, Year)
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	_		30, Name and arciresplot berson w	to completed faugle of d	eath (Hom 23a)	Le.	Print) Ro	. BA	th	My 2	1237		
	Sta Registi	-	31. Date filed (Maritt, day, Year) JUL 1 3 1999	Server 32. Registr	ars Signature	Los	uls						



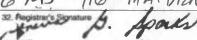
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month 7 -Pm William Baldwin Heiliger 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1013 Regina Dr. Arbutus Baltimore 8. Data of Birth (Month, Day, Year) Sent. 5, 1920 If Under 1 Year | If Under 24 Hrs. 9. Birthplaca (Stata or Foreign Country) Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 10 M 20 F 214-16-6941 78 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2X No Director Baltimore Arbutus 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 1013 Regina Dr. 21227 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 AYes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Specify: White 1 Yas 2 XNo Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Mechanic Steel Can Production 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) 86 John Walter Heiliger Clara Baldwin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1013 Regina Dr., Arbutus, MD 21227 Jean T. Heiliger, Wife 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Louden Park Cemetery 7-10-99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Addrass of Facility Ambrose Funeral Home 2719 Hammonds Ferry Rd. Lansdowne, MD 21227
Do not enter the mode of dying, such as cardiac of respiratory arrast, Approximata 23a. Part 1. Enter the disease, or complications that cause shock, or heart tailure. List only one cause on each Intarval Between Onsat and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed 1 ☐ Yas 2 1 No 1 ☐ Yas 2 No Be 25. Was case refarred to medical axaminer? 26. Place of Death (Check only ona) 210 No Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) edical Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manyler of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and titla of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAIDEN CHOICE CN, 716 31. Data filed (Month, Day, Year)

State Registrar

JUL 1 3 1999



DHMH 16 Ray 6/95

Physician /Medical Examiner **Funeral**

Director

show 288-1 Rarras 23a or filed within 72 hours after "natural", or Hygiene.

Baltimore, Maryland 21215-0020 Pages 1 and 2 should be filed vinent of Health and Mental Hygis ent; if Ibem 27 is marked other Department of Health I Important: If Item 27 is any injury or other tre **Physician** /Medical Examiner

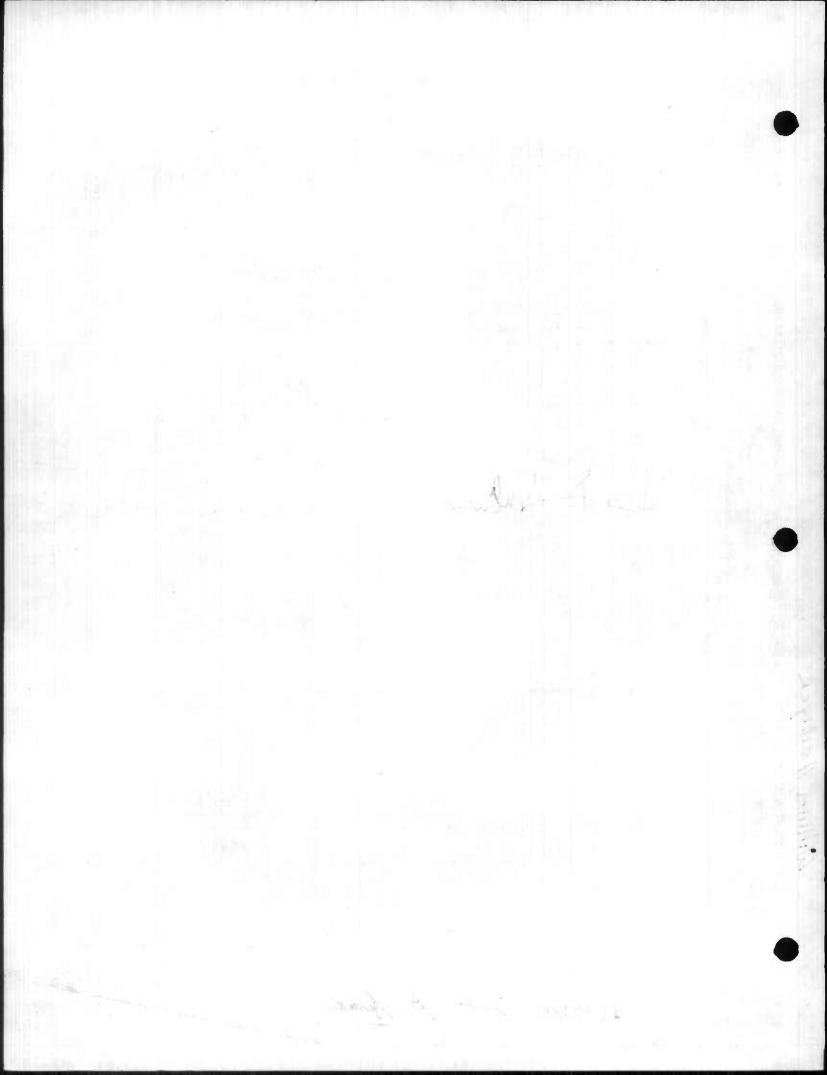
physician and s the burial-transit

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n 24 hours after death.

The Funeral Director: After pletely filled in by the fun

Records, P.O. Box 68760 Heiliger



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 9 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July 1999 Edwin August Harrer 9:15 AM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Baltimore Joseph Richey Hospice 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Pay, Year) May 25, 1918 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1₽M 2□F Months Days 218-07-9309 Baltimore Yrs. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 820 N. Eutah St. 21201 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☒ No Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Labor Clerk Distillery 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) John Harrer Bertha Goetzinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert Wood- Stepson 27 Bluebell Dr., Selbyville, DE 19975 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) Dete 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 7-12-99 Meadowridge Mem. Park Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 25. Signature of Funeral \$ Ambrose Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Appendix Appe Interval Between Onset and Deeth Immediate Cause (Final kone & liver disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es e consequence of Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Wes an autopsy completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical axeminer? 28. Place of Death (Check only one) Hospitel: 1 Inpatient 2 EN/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 1 ☐ Yes 2 1 No 28d. Describe how injury occurred 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident

physician the signed by t this

Examiner Physician/Medical by Completed 10

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within.
Department of Health and Mental Hygiene.
Important: if hem 27 is marked other than any linking or other traumation.

Physician /Medical

Examiner

the Marylend

Box 68760 Division of Vital Records, P.O. or Attendation of the death 24 hours a To the Hosp within 24 ho To the Fune completely fi

SR

HARR

A.

Edwin

State Registrar

Medical

29b. Signature and title of cartifier

6 Could not be determined

3 Suicide

29a. Certifier

4 | Homicide

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examinar: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. toges, KM W.C

29c. License number D 02290 29d. Date signed (Month, Day, Year)

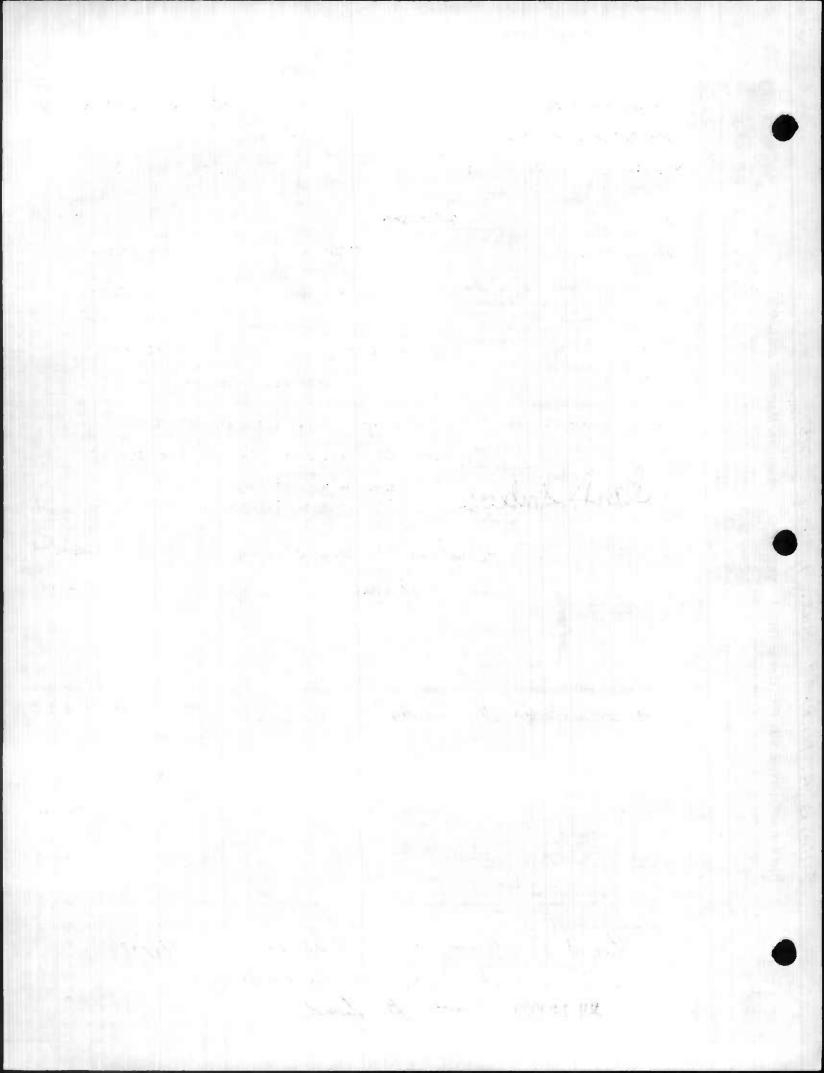
28f. Location (Street and Number or Rural Route Number, City or Town, State)

ress of person who completed cause death (Item 23a) (Type, Print)

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Linken to Ballo 21201

32. Registrer's Signeture



Certificate of Death 2. Date of Death 3. Tima of Death Day Month 1945 JULY 10 1999 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours March 1, PA 10c. City, Town or Location 10d. Inside City Limits Catonsville 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 21228 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White 1 Yes 2 No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry \$tate of Maryland Dept. of Education Accountant 18. Mother's Name (First, Middle, Maiden Surname) Ruth M. Burgee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 252 Blakeney Road, Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 7/14/99 Woodlawn, MD Lorraine Park Cemetery 22. Name and Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ORGAN 2 weeks Due to (or as a consequence of): 2 weeks Due to (or as a consequence of): Failure 2 weeks Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 ₽No 1 Yas 2 No

Completed Be Certification: To

edicai

certificate Attending Physician: this After death. Director: hours after 6 24 hours

Division

AM

25. Was case referred to medical axaminer? 1 Yes 2 No 27. Manner of Death

5 Pending 1 Matural 2 Accident 3 Suicide 4 Homicide

investigation 6 Could not be determined 28a. Date of tnjury (Month, Day Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1 Dispatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

26. Place of Death (Check only one)

281. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

28d. Describe how injury occurred

Baltimore MD

29b. Signature and title of certifier

(Check only one)

MD

29c. License number 108

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Data signed (Month, Day, Year) JULY 10

1999

21229

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) 900

OJEDA HERMINIO 31. Date filed (Month, Day, Year)

Hermone

32. Fledistrar's Signature JUL 13 1999

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Ave. CATON

State Registrar

DHMH 16 Rev 6/95

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early to an early strain of

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death HAII Month AMES Jul 4b. City, Town, or Location of Deeth 4a. Facility Nama (If not Institution, give street and number, 4c. County of Death 758 Match Point Drive Anne Arundel Co. Arnold Hours Min. 8. Date of Birth (Month, Day, Year) April 16,1939 5. Social Security Number 220–36–7669 7. Age (In yrs. lest birthdey) 60 Yrs. If Undar 1 Year Birthplace (State or Foraign Country) 1 XM 2 ☐ F Days Maryland Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Co. Maryland Arnold 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 758 Match Point Drive 21012 U.S.A. 12. Was Decadent Evar in U,S. Armed Forces? 1 Mary Yes 2 □ No If Yas, Give Year or Dates: 11. Marlfal Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, efc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education ify only highest grede completed) 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest gi Board of College (1-4or 5+) Elementary/Secondary (0-12) Maintenance Supervisor Education 12 N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Bradley Hall Susie Anna Hall 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Jamie J. Hall Daughter 3501 Lockearn Ct. #B Pasadena, Maryland 21122 20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State Arnold Asbury United 4 ☐ Donetion 5 ☐ Other (Specify) 7/16/99 Arnold, MD Methodist Church Cem. //10/29 Alloud, 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 21. Signatura of Funeral Servica Licensee llon 3204 Mountain Road Pasadena, Maryland 21122 23a. Part1. Enfar tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between immediate Ceuse (Final Arteriosclerotic Heart Disease disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yas 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1X Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Physiclan /Medical Examiner

Physician

/Medicai

Director

Funeral

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Completed

Be

Examiner

Funeral

Director

tem 27 is marked other than "natural", or items 23a or 28a-f ehow other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death w Departmant of Haalih and Mental Hygiena. Important: if flem 27 is marked other than "natural", or items 23a, any injury or other traumatic event.

Baltimore, Maryland 21215-0020

tha Maryland

and Records, P.O. Box 68760, attending physician for usa as the buria ata has been signed by paga 2 should be datac cartificata Division of Vital the Hospital or Attending Physician: hin 24 hours after death. Aftar this

Physician/Medical by Completed Be Medical Certification:

27. Manner of Death

3 Suicide 4 T Homicide 29a, Certifier

Naturai 2 Accident

31. Date filed (Month, Dev, Yeer)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cartifier

Deputy

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

D06054

29d. Date signed (Month, Dey, Year)

281. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how Injury occurred

and address of person who completed gauss of death (Item 23a) (Type, Print) oves, mo

695 America 21035

State Registrar

5 Pending Investigation

6 Could not be determined

32. Registrar's Signature

28a. Date of Injury (Month, Day Year)

Director:

within 24 hours a To the Funeral C

Arrence who who Henry Disease court Address Against

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Dete of Deeth 3. Time of Death Month 01-6:30 WALTER 99 HARRIS 0 -4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GREEN (JEVESIS NIA ONG If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Deys 1 M 2 □ F 215-16-6645 76 Yrs. MD Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limita 1 Yes 2 No NIA BALTIMORE MO 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 1401 ULIVER STREET 21213 12. Wes Decedent Ever in U,S.
Armed Forces?

1 Yes 2 □ No Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, Whita, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify BLACK 3 □ Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College_j(1-4or 5+) EMPOYED GRADE GROCERY NIA 12 14 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) VIOLA CURRY HARRIS JUAN 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) ST. 1401 E OLIVER BAGO. MD 21213 HARRIS 211 WIFE APT LAURA 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete TOREST CEMEJERY 7-13-99 UWINGS MILLS, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Libersee 22. Neme and Address of Fecility
VAUGHN C. GREENE FUNERAL SERVICE was or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest,
List only one cause on each line. au 21229 Approximete Intervel Between Onset and Deeth 10 days Immediete Ceuse (Finel disease or condition resulting In death) Due to (or es e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or as a consequence of) that initieted events resulting in death) Lest Due to (or es a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evelleble prior to completion of ceuse of deeth? 24e. Was an autopey 2X No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical axaminer? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28c. injury at Work? 28d. Describe how Injury occurred 28b. Time of 1 Neturel 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

Box 68760 Division of Vital Records,

requires that the death certificata be

State Registrar

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Physician/Medical Examiner

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Completed

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2

Certification:

Medical

29a. Certifier (Check only one)

Director

7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examiner name be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiena. Important: if frem 27 is marked other than "natural", or ferma 23a any Injury or other traumatic event, the Wed

Physician

/Medical

Examiner

attending physician and for use as the bunal-transit

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certificate

within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di

funeral director,

or Attending Physician:

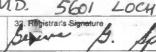
Hospital

88

SPERLING 31. Dete filed (Month, Dey, Year)

JUL 1 3 1999

29b. Signature and title of certific



30. Name end wodress of son who completed ceuse of deeth (Item 23a) (Type, Print)

MD.

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

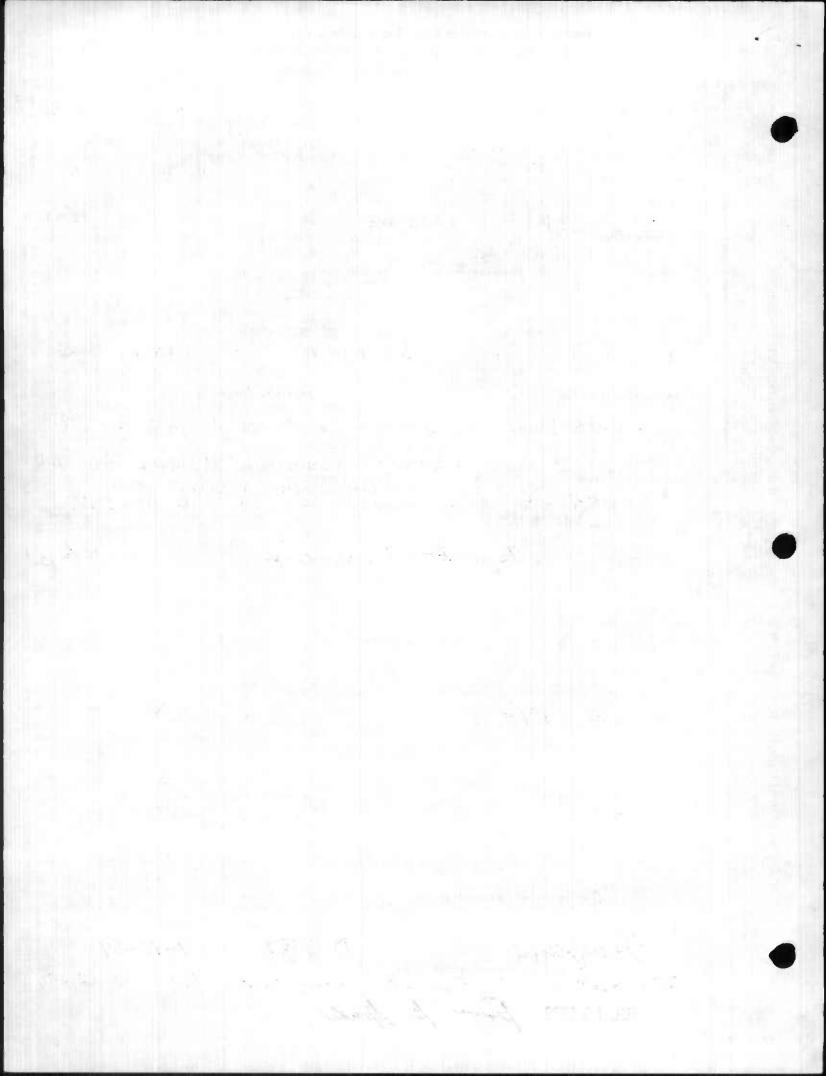
2 Madical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29c. License number

RAVEN BLUD

29d. Dete signed (Month, Day, Year)

BALTO. MD 21239



di le li	10e PER FH G7737/1			Ce	rtificate d	of Death	nd Mental	Reg. N		21030
Physician	1. Decedent's Neme (First, Mic	ddle, Last)	s. s	. н	INNANT		2. Dete d Month	D	ay Yes	3. Tima of Death 1700 PM
/Medical Examiner	MARIA 4a Facility Neme (If not institut			. п	INNANI	4b. City, Tow	n, or Location of D		. 1999 c. County of D	eeth
Examiner	1623 WEST NOR	TH AVENUE				BALT	IMORE		N	I/A
Funeral Director	5. Social Security Number 214 64 5794	6. Sex 1 □ M 2 F	7. Age (In yrs.	last birthday) O Yrs.	ff Under 1 Ye Months De	eer If Under 2 eys Hours	4 Hrs. 8. Dete c (Month	Birth Day, Year 31-58	9. 8	Birthplace (State or Foreig Country) MD
	Usuel Residence of Decedent 10a. State 10b. Cour			ity, Town or Lo	cation					10d. fnside City Limit
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or 28a-f s be notified Director	MD 10e. Street and Number	N/A		D	ALTIMOR 10f. Zip Coo			10g. C	itizen of Whet	1
3a or	1623 W. NOR	TH AVENEU	AVENUE			21217			US	A
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B story	17. Father's Name (First, Middle MAURICE STE						's Neme (First, Mi		n Sumame)	
and Mentalis is marked sumatic e	19e. Informent's Name/Reletio	onship (Type, Print)		19b. Meili	ng Address (St	reet end Number	or Rural Route N	umber, City	or Town, Stet	e, Zip Code)
of Health of Health I ltem 27 r other tr	STEVEN HINNAN 20a. Method of Disposition 1 X Buriel 2 Crematio		20b. l	Plece of Dispo	WEST N sition (Name of metory or other	d	ENUE BAL'			21217 or Town, State
artment ortant: I injury o	4 □ Conation 5 □ Other		K	ing N	lem PK	۲.	7159	9 Ba	elto. N	Nd.
Departiment important in any in any in any in and any in and and any in	2/ Signature of Funerel Service	1 Wis	Ten	J	AMES A.	ddress of Fecility MORTON	& SONS	FUNERA	AL HOME	E. INC.
	1	and the same of th		1	701 TAT		DATES			,
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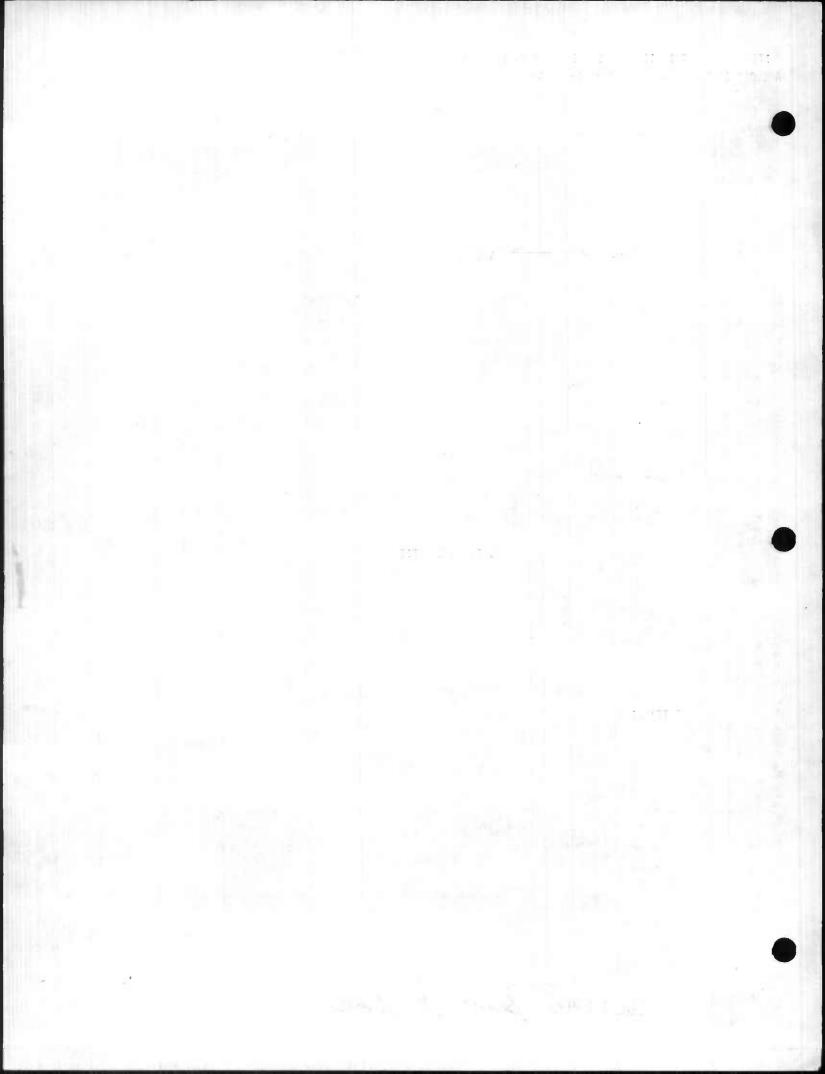
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State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** HEFFERNAN JULY 02:15 PM WILLIAM 05 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1₩ 2□F Months Days 1943 Illinois Director 318-36-0365 Feb. 23, Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f ahow Examiner must be notified at 1 X Yes 2 No Director Millersville MarylandAnne Arundel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Herns 23a 21108 United States 211 Finnegan Drive death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. should be filed within 72 hours after ond Mental Hygiene.

marked other than "natural", or Itel 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) travel 12 tour agency owner permit. Pages 1 and 2 should be file Department of Health and Mental Hy, important: If item 27 is marked other any injury or other traumatic avant, phose. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Janet Lake Joseph Francis Heffernan 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Lewis Heffernan - wife 211 Finnegan Drive, Millersville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Free Union Baptist Church 7/9/99 Free Union, Virginia 21. Signaturerol Funeral Service Licen 22. Name and Address of Facility Teague Funeral Service 2260 Ivy Road Charlottesville, Virginia 22903 23a. Part1 Enter the disease, or come shock, or heart failure. List only ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, no cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Finat disease or condition resulting In deeth) /Medical 40 MONTHS . CHOLANGIOCARCINOMA METASTATIC TO LUNGS Examiner Due to (or as a consequence of): Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Records. by The law requires 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 X No 1 Yes 2 No Division of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Naturat 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation hours after death uneral Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hour.
The Funeral Direction of the control of 6 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hou To the Funer completely fil 29a. Certifier Medical 29b. Signature and titte of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

PROWELL

DHMH 16 Ray 6/95

RES-000

JOHNS HOPKING HOSPITAL 600 NORTH WOLFE ST BALTIMORE MD

JULY 05, 1999

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician 1:04 am CANDIS HARGRAVES 1999 JULY 10 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner BALTIMORE CITY UMAB: 22 SOUTH GREEN BALTMORE, MD 21201 BALTIMORS 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

| Months | Days | Hours | Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 83 Yrs. 237-22-7682 Director 01/28/16 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits #pq# BALTIMORE r 28a-f sh notified N/A MD. 1 Xes 2 No Director 100 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b munt be 21225 2546 TERRA FIRMA ROAD USA Items 23a Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Status Bleck, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Merried 21215-0020 'natural', or 1 ☐ Yes X No Specify: BLACK Specify: à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiere. Elementary/Secondery (0-12) College (1-4or 5+) TEMPLE GARDENS RECEPTIONIST 12TH GRADE permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If Item 27 is marked
any Injury or other marked other Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be GEORGE CLEMENTS SARAH DORHAM 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JANIE G. SANDERS 2546 TERRA FIRMA ROAD BALTIMORE, MD. 21225 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 Deurial 2 Cremation 3 Removel from Stete 4 Donation 5 Other (Specify) JULY 14 BALTIMORE, MD. ARBUTUS MEMORIAL PARK 22. Name end Address of Facility NUTTER FUNERAL HOMES, INC. 21. Signeture of Funeral Service Licenses E 1 the 2501 GWYNNS FALLS PKWY BALTIMORE, MD. 21216 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediete Cause (Finel disease or condition resulting in deeth) ONE WEEK Examiner Due to (or as e consequence of): Examiner YONE WEEK CHULANGITIS certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 7SIX MOVINS Box 68760 PANCAGATIC CANCER Physician/Medical Due to (or as a consequence of) 88 P.O. ed by the detached Pert II. Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 € No 3 Probably 4 Unknown DIABETES MOLLITUS Records. ğ The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed HYPERTENSION 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical eleipf filled in by the funeral director; 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) t ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number PLANE 12407 JULY, 10th 1999 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Registrar **DHMH 16 Rav 6/95**

State

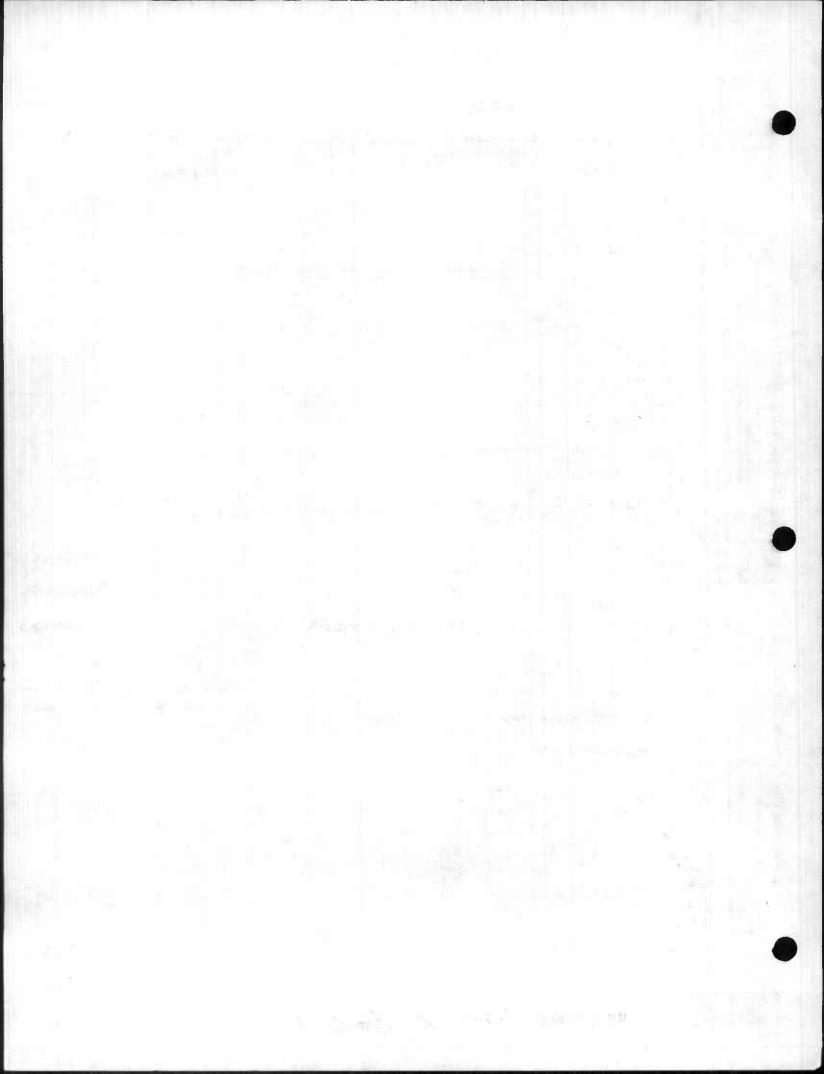
31. Date filed (Month, Dey, Year)

32. Registrar's Signeture

JUL 1 3 1999

Sporks

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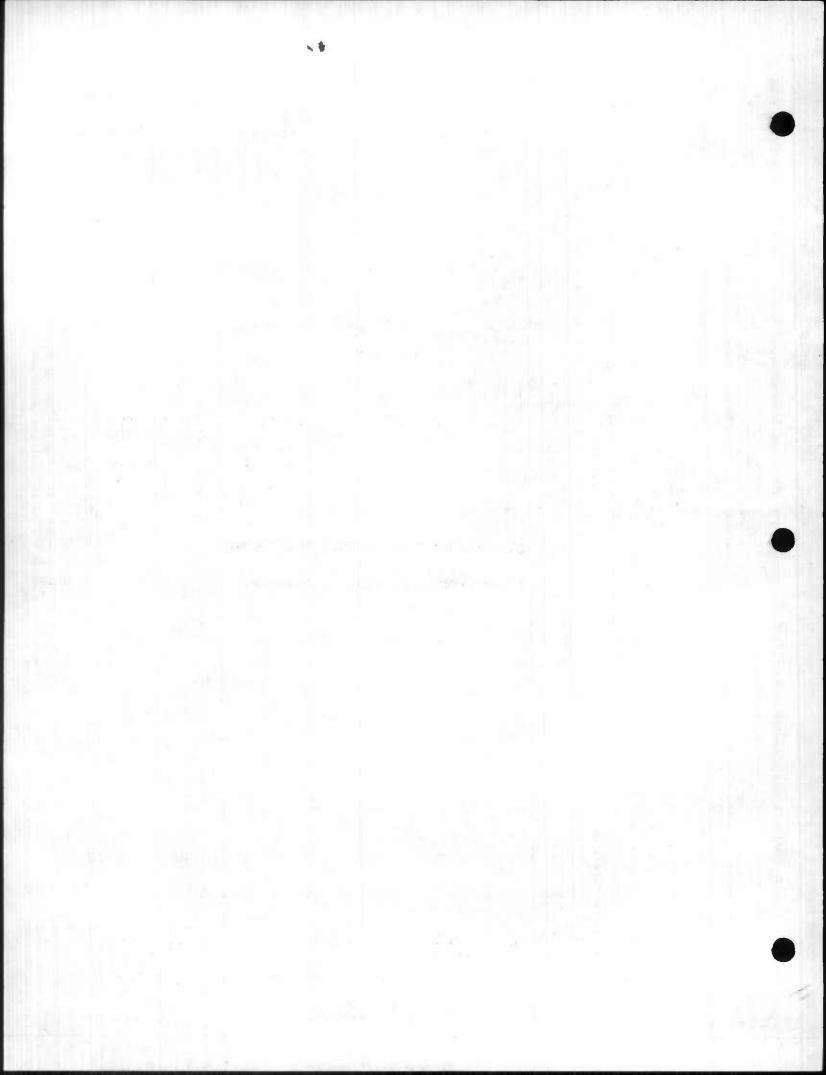


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State of Maryland / Department of Health and Mental Hygiene 99 21899

			Cel	TITICATE	of Death	R	eg. No.				
	1. Decedent's Nama (First, Middla, Las	st)	Trans.			2. Data of Dear	th		Time of Death		
	MARGARET	MARY		HALI		Month JU	LYay 8, 1	939 06	5:55PM		
	4a Facility Nama (If not institution, give Saint Joseph		nter	40	4b. City, Town, o	Location of Death	4c. County	of Death altimo	ore		
	5. Social Security Number 220 – 24 – 1 3 0 4 1	DM ARE	70 Yrs.	If Under 1 Months I	Yaar If Under 24 Hr Days Hours Mi			9. Birthplace (Country) MD	Stata or Foraign		
	Usual Rasidence of Decedant 10a. Stata 10b. County	100	City, Town or Lo	cetion				tOd In	side City Limits		
ctor	Md. Worce		Ocean						□ Yas 2 XNo		
	10e. Street and Number 8400 Caribbia	n Ave.		10f. Zip C 21	ode 842	1	0g. Citizen of V USA	Vhat Country?			
	11. Mantal Status 1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evar i Armed Forcas? 1 ☐ Yas 2 ☑ No if Yas, Giva Year or Dataa:		Was Deceder f Yas, specify	nt of Hispanic Origin? (Cuban, Mexican, Pue No Specify:	Specify Yas or No- into Rican, atc.)		e - American Ind kk, Whita, atc.			
Ī	15. Decedent's Ed (Specify only highest gra-	ucation de completed)	16a. Deced	dent's Usual (Occupation done during most of w retired)	orkina	16b. Kind of Bu	islnass/Industry			
Section 1	Elemantary/Secondary (0-12)	College (1-4or 5+)			operator		Weste	rn Ele	ectric		
	17. Father's Name (First, Middla, Last)			ame (First, Middle, I	Maiden Sumam	ia)					
To Be Completed by Physician/Medical Examiner To Be Completed By Physician/Medical Examiner To Be Completed By Physician/Medical Examiner To Be Completed By Physician By Physician By Physician By Physician By Physician By Physician By Physician By Physician By Physician By Physician By Physician By Physician By Physician By Physician By Physician By Physician By Physician By Physician By Physici	Maurice J. Su	llivan			Mary	Agnes K	earney				
	19a. tntormant's Neme/Reletionship (7	Type, Print)	19b. Meilir	ng Address (S	Street and Number or I	Rural Routa Number	r, City or Town,	Steta, Zip Code)		
	Patricia Schu	ltz /sist	er 7836	Locl	cwood Rd	Balti	more,	MD 212	222		
	20a. Mathod of Disposition 1 ☒ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from Stata	b. Place of Dispo cematary, crem	natory or othe	of Jesu	fuly 12		City or Town, S			
	21 Signature of Scheral Service Licent		22	Conne	Address of Facility ITY Fune: Sollers	ral Home	of Di	undalk			
liet	Immediata Causa (Final disease or condition rasulting in death)	a. Due t	o (or es a conseq	quence of):	US BACTE			4	DAYS WEEK		
	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or as a consequence of):									
Σ	that initiated evants rasulting in death) Last	Dua to (or as a consequence of): d									
	Part II. Other algorificant conditions on RENAL FAILURE	23b. Did to		3 Probably	4 Unknow						
24a. Was an autopsy performed?								avaliable	atopsy tindings a prior to ion of causa ?		
						1 🗆 Y	es 2 XNo		2X No		
9	25. Was case referred to medical axaminar?				26. Place of D	eeth (Check only or	18)				
0	1 Yas 2 No	Hospitel: 1 Inpatient	ER/Outpatien	t 3 DOA	Other: 4 Nursing	Homa 5 Reside	ence 8 Oth	ar (Specify)			
	27. Mannar of Death 1 Natural 5 Pending invastigation		28b. Time of Injury	M 280	Nork? 1 Yas 2 No	28d. Describe h	ow injury occur	red			
	3 Suicida 6 Could not be 4 Homicida detarmined	28e. Plece of Injury - A building, atc. (Sp.	t homa, tarm, str ecify)	eet, factory, o	office	28t. Location (Si City or Town		er or Rural Rou	ita Number,		
		yalcian: To the best of my iner: On the basis of exam and manner steted.									
edica	one)			1		1 2	Oct. Patte signal	(Month, Day,	Veer		
	29b. Signatura and title of certified	form	D	29c. t	icense number 24034		7/8/	99	routy		

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State of Maryland / Department of Health and Mental Hygiene

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Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death J Mostly 13 Day 199 Ygar **Physician** 3:00AM Hilda Jennings /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maryland Masonic Homes Cockeysville Baltimore 8. Data of Birth (Nonth, Day, Year) 0 / 1 0 / 1908 5. Social Security Number If Undar 1 Yaar If Undar 24 Hrs. 7. Aga (fn yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1 M 2 F Min. Months Davs Hours 215-22-4797 91 Yrs. Director Maryland Usual Rasidance of Decedant 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show 10a, Stata 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hybinea. Important: if then 27 is anxived other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Mindigal Energine must be notified at 10d. Inside City Limits 1 Yas 2 No Director Baltimore Cockeysville 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 300 International Cir. 21030 Funeral USA 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: White à 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Nurse Health Care 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Be William L. Seckman 2 Bessy Mae Greenwade 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Wendy Warner/Guardian 300 International Cir. Cockeysville, MD 21030 20b. Place of Disposition (Nama of competary, crematory or other place)
Baltimore Washington Crematory 20a. Mathod of Disposition
1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 20c. Location - City or Town, Stata July 13 4 ☐ Donation 5 ☐ Othar (Specify) Laurel, MD 21. Signatura of Funaral Sarvice License 22. Nama and Addrass of Facility
Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 Michael J. Flag1e Approximata Intarval Between Onsat and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Physician Immediata Causa (Final diseasa or condition rasulting in daath) /Medical Examiner Dua to (or as a consaquance of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Cause (Disaase or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Records, P.O. Box 68760, Physician/Medicai Dua to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 WUnknown þ 24b. Wara autopsy findings available prior to completion of cause of death? been si 24a. Was an autopsy performed? Completed hes 1 Yas 25 No 1 ☐ Yas 2 ☐ No certificate Division of Vital or Attending Physician: effer death. Director: After this certifica funeral director, 25. Was casa refarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Death Certification: 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Panding 1 Yas 2 No Invastigation 2 Accidant 6 Could not be datarmined 3 Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicida To the Hospital of within 24 hours of To the Funeral Discompletely filled it 29a, Cartifiar (Check only one) Excertifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and piace, and dua to tha causa(s) and mannar as stated. Medical 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tilla of certifiar 29c. Licanse number 29d. Data signed (Month, Day, Year)

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State Registrar

31. Data filed (Month, Day, Year)

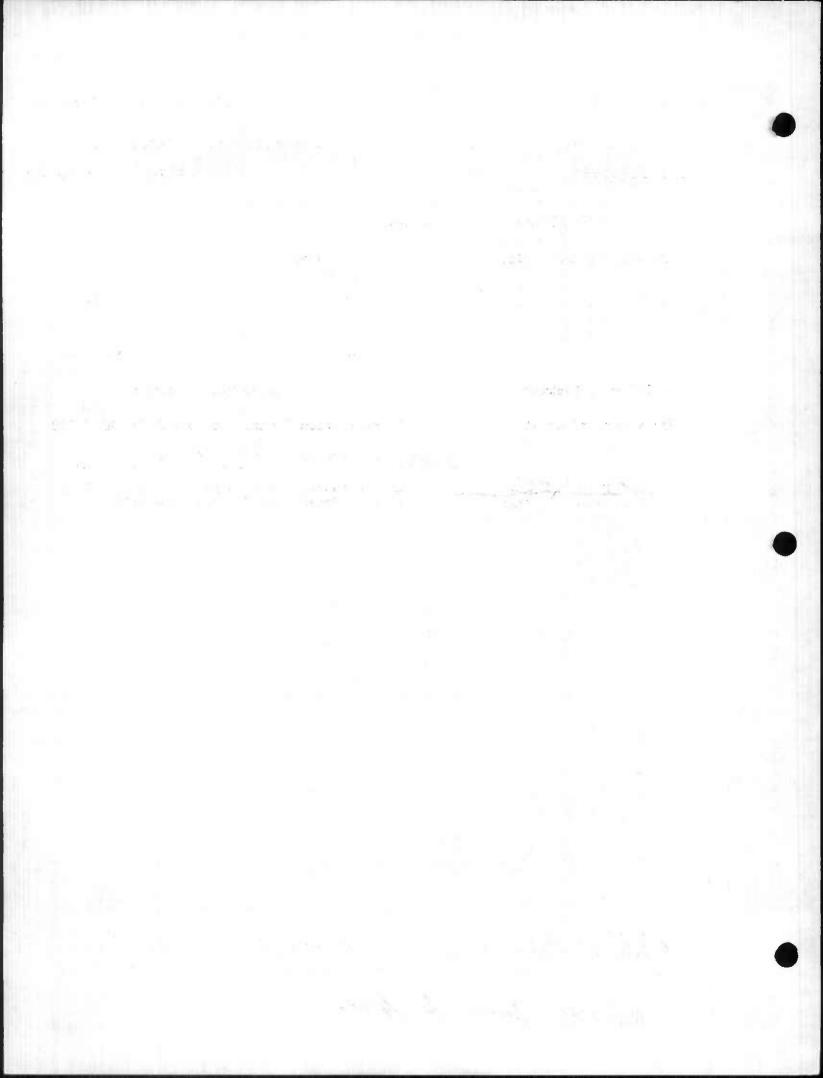
1 3 1999

30. Name and addrass of person who complated causa of death (Itam 23a) (Type, Print)

John W. Bowie, M.D. 6800 York Road Baltimore MD 21212

32. Registrar's Signatura

DHMH 16 Ray 6/95

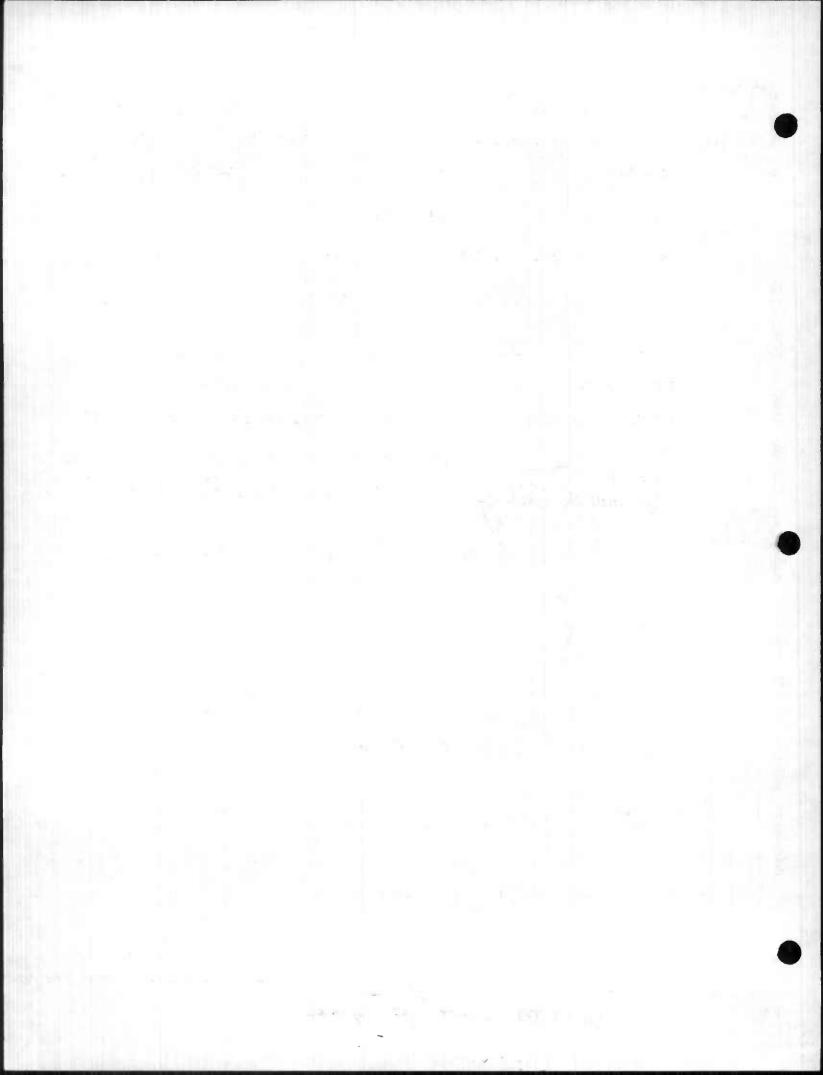


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State of Maryland / Department of Health and Mental Hygiene

21901

				Certificate of			Reg. No.	61201		
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Herperta. Tackson			2. Date of Dec	8 9°	3. Time of Death		
ı	Exami	ner	4a. Fecility Neme (If not institution, give street end number) 827 ARLINGTON AVE. APT.203				4c. County of D	eath		
	Funerai Director		5. Social Security Number 6. Sex 7. Age (In yrs. lest bin 200–20–4854 70	rthdey) If Under 1 Year Months Days		8. Date of Birt (Month, De) 2-22-	h a	Birthplace (State or Foraign Country) MD .		
	Maryland a-f show filed at	tor						10d. inside City Limits 1 → Yes 2 → No		
	ath with the	ral Direc	10e. Street and Number 827 ARLINGTON AVE. APT. 203				10g. Citizen of Whet	Country?		
020	urs efter de	by Funeral Director				ecify Yes or No- Rican, etc.)	Canaitu	American Indian, Vhite, etc.		
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Deportment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examinet must be notified as once.	Completed	15. Decedent's Education (Specify only highest grede completed) Elamentary/Secondary (0-12) College (1-4or 5+) -8 -		pation during most of workii d)	ing	16b. Kind of Busine			
	al Hygi cother	Be Co	17. Father's Name (First, Middle, Last)	A Date of Mooth Asserting give street and number) TON AVE. APT. 203	(First, Middle,					
Maryland	should be nd Mental marked o	To								
	and 2 sh eaith and n 27 ls n									
Baltimore,	Pages 1 gment of He ant: If Item		1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal Irom State 4 ☐ Donetion 5 ☐ Other (Spacify) GARRIS	ry, cremetory or other pleased N FOREST V	ETERANS 7	-15-99		LLS, MARYLAND		
Ball	permit. Depertuimporta any Inje		21. Signature of Funeral Service Rockson Lectron L. Dulley	1721-27 N.	MONROE S	T. BALT	IMORE, MA			
Box 68760,	Physician /Medicale pe executed pupple feeding physician and pupple feeding physician and pupple feeding physicians it is a set to be properly and pupple feeding pupple fe	an/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last Due to (or as a condition of the cause of th	consequance of):	rdiòvas	ular	disease	Onset and Death		
P.O. E	thet the death certined by the ettending detached for use	Physician/N	Part II. Other significant conditions contributing to death but not resulting in		ven in Part i.	23b. Did t	obacco uee contrib	oute to the cause of death?		
Records, P.	v requires been sign should be	Completed by Ph	Persperal vasular	on disease		perfor	an autopsy med?	4 Unknown b. Wera autopsy findings evalleble prior to completion of cause of death?		
		Be Co	25. Was casa raferred to medical		26. Place of Death	1 U		1 ☐ Yes 2 ☐ No		
Division of Vital Reco	To the Hospital or Attending Physic within 24 hours effer death. To the Funeral Director: Affer this ce completely filled in by the funeral directions.	Certification: To E	27, Manner ol Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	Tima of njury M 1	ry at rk? Yes 2 \Bo	28d. Dascribe h	now Injury occurred	,		
DIV	To the Hospital or All within 24 hours efter or To the Funeral Direct completely filled in by		4 Homicida determined 28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify) City or Town, Stete)							
	n 24 h	edicai	2 Medical Examiner: On the basis of examination and	d/or Investigation, in my o	ppinlon, death occurre	ed at the time,	date and place, and	due to the cause(s)		
	With Tot	Σ	29b. Signature and title of certifier M	Di	20040		29d. Date signed (M	onth, Day, Year)		
	Sta Registi		30. Name and addrass of person who completed cause of daath (Item 23a) (31. Data liled (Month, Day, Year) 32. Registrac's Signature	Type, Print) Les prints S. Soon	on Blue	Ral	timere,	Md 2/230		

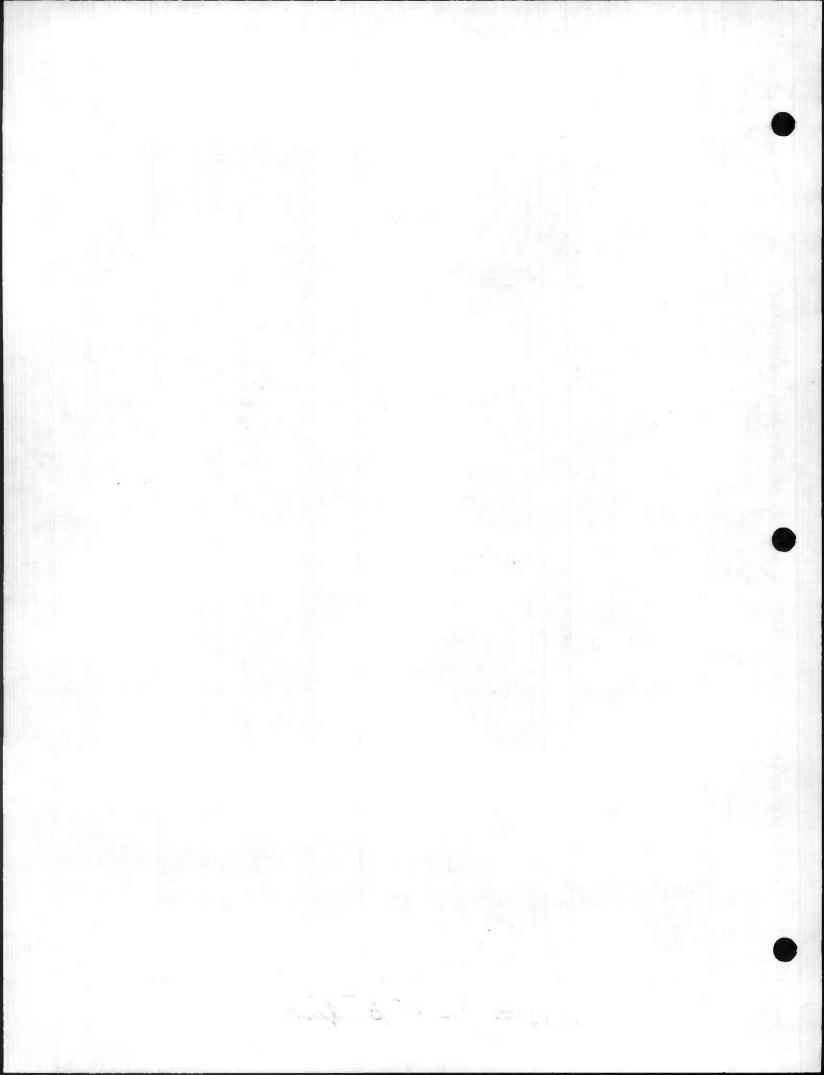


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 1914 PM **Physician** 9, Lillian Alberta Jacobs 1999 JULY /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAYVIEW MEDICAL CENTER BALTIMORE N/A If Under 24 Hrs H Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 13, 1 Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Months Hours 492-10-5773 81 Director Kansas Usuel Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 23a or 28a-f ahow 1D Yes 2 No Baltimore N/A Maryland 10e. Street and Number 10f. Zin Code 10g Citizen of What Country? To 21206 United States 4911 LaSalle Avenue Funeral Nome : 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 Never Merried 2 Merried natural, or Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: py 3 N Widowed 4 Divorced White Yeer or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If them 27 is marked other tha any Injury or other traumatic event, Imal page. Clothing Seamstress 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elizabeth Brenton Alta Hayes 19a. Informant's Neme/Reletionship (Type, Print) 19b. Melting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland Mr. Robert J. Foerster (son) 4911 LaSalle Avenue 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from Stele 7/13/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Parkwood Cemetery David 22. Name end Address of Facility 21. Signeture di Fuperet Service Licensee Christina 5305 Harford Road LEONARD J. RUCK, INC. Baltimore, MD 21214 23e. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finei , Hypertensive Arteriosclerotic Cardiovascular Disease disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and s the burial-transit certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760 Physician/Medicai Due to (or as a consequence of) P.0. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably XX Unknown Records, é 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? INSPECTION The law page 2 1 Yes 1 Yes 2 No certificate 2XNo Division of Vital Hospital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) XX Yes 2 No Certification: To 1 Inpatient 2XER/Outpatient 3□ DOA this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death Director: A 2 Accident 6 Could not be determined 3 ☐ Sulcide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pieca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D completely filled in edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated.

**Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and magnet stated. 29a. Certifier 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. JULY 10, 1999 30. Name and address of person who completed cause of deeth (item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 David Fowler, M.D.

State Registrar 31. Date filed (Month, Day, Year) JUL 13 1999

32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent'a Name (First, Middla, Laşt 2. Data of Death 3. Time 1 th Month MARIE Janson helma 1145a 1999 10 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Hospital Samaritan Baltimore 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) If Undar 1 Yaar if Undar 24 Hrs. 8. Data of Birth (Month, Day, Year)

July 7, 1921

9. Birthplaca (State or Foreign Country)

South Carolina Birthplaca (Stata or Foreign Country) 10 M 2 XF Months Days Hours 247-14-8732 78 Yrs. Usual Rasidance of Dacadant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 XYas 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 6401 Loch Raven Boulevard #525 21239 United States 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armad Forcas?
1 ☐ Yas 2 ☐ No Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxlcan, Puarto Rican, atc.) 1 ☐ Nevar Married 2 ☐ Married If Yes, Giva Yaar or Datas: 1 ☐ Yas X ☐ No Specify: White 3 Widowad 4 ☐ Divorcad 15. Decedant's Education 16a. Dacedent's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratired) (Spacify only highast grada complated) Elementery/Secondary (0-12) Collaga (1-4or 5+) 12 Medical Secretery Medical 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumema) William T. Koester Mary Unknown 19e. Informant's Name/Raletlonship (Type, Print) 19b. Mailing Address (Street end Numbar or Rural Routa Number, City or Town, Stete, Zip Coda) 5010 Arabia Avenue Mr. Roman Philip Janson / Son Baltimore, MD 21214 20b. Place of Disposition (Neme of camatery, cramatory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 XBurlal 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Holly Hill Memorial Gardens 7/13/99 Baltimore, Maryland 21. Signatura of Funaral Sarvice Licensee Timothy Harman 22. Nama and Addrass of Facility Inc. Funeral Home Leonard J. Ruck, 5305 Harford Road Baltimore, MD 21214 23e. Pert1. Enter the diam's e, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock, or hear feil in List only one causa on each line. Approximete Intarval Batween Onsat and Death Immediete Ceuse (Finel disaasa or condition rasulting in daath) ongestive tery disease Coronar Due to (or as a consaquanca do: Dua to (or as a consequanca of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24a. Was an autopsy completion of causa of death? 1 Yes 26. Placa of Death (Check only ona) Hospital: Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred 5 Panding invastigation 1 Yes 2 No

Examiner Examiner The law requires that the death certificate be executed physician and as tha burial-trans Box 68760, Physician/Medical usa as P.O. ed by tha e signed b Records, þ Completed page 2 s certificata Division of Vital or Attending Physician: Be 2 this funaral Certification: Aftar To the Hospitat or Attendit within 24 hours after death.

To the Funeral Director: At completely filled in by the fu daath.

Physician

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Physician

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Baltimore, Maryland

the Medical Examiner must be notified at

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Saquantially list conditions, if any, leeding to immadiata cause. Entar Undarlying Cause (Disaasa or injury that in its tool awards. that initieted evants rasulting in deeth) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 25. Was casa rafarred to medical axaminar? 1 Yas 27. Manner of Daath 1 Naturel 6 Could not ba 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) datermined 4 Homicide

29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et tha time, dete and plece, end due to the cause(s) end mannar as steted.

Medicat Examiner: On tha basis of exeminetion end/or invastigetion, in my opinion, daath occurred et the time, dete and place, end dua to the ceuse(s) and mannar statad. one) 29c. Licansa number 29d. Data signed (Month, Day, Year)

29b. Signatura and titla of certifian

Physician 00054303 10,1999

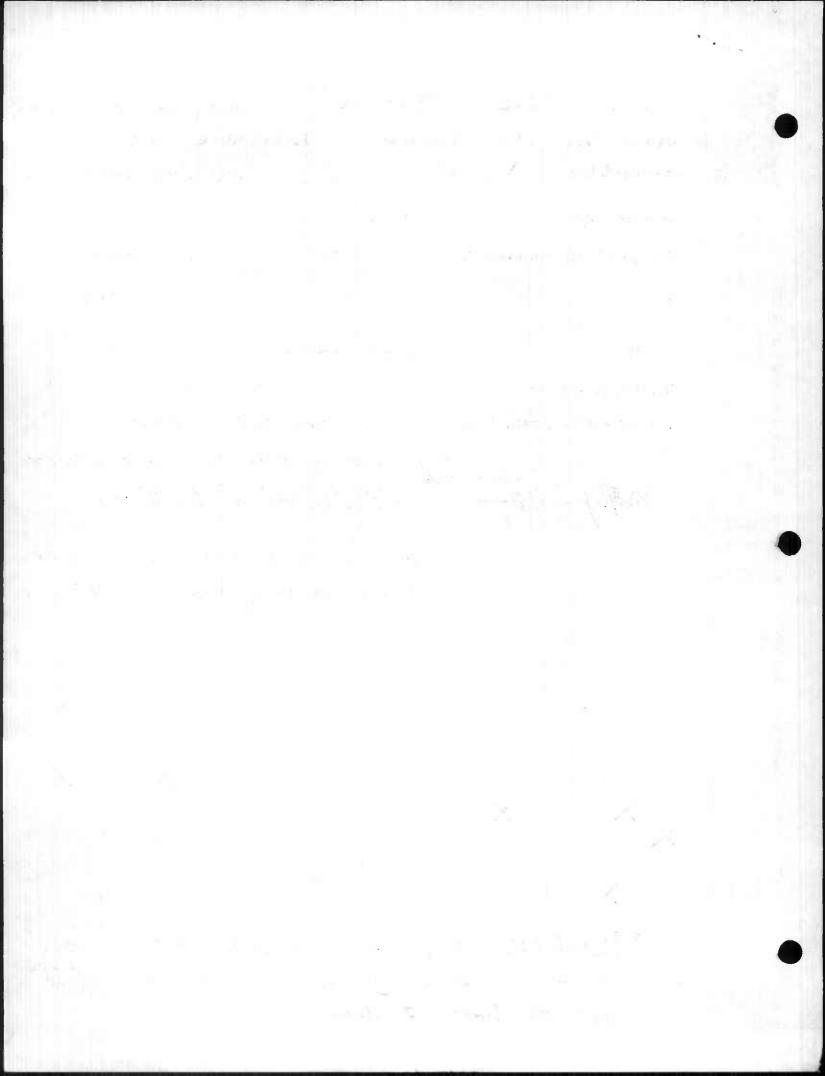
ress of person who completed causa of daath (Item 23e) (Type, Print) 5601 Lock Raven Boulevard Baltimore, Maryland HADADAH

31. Data filed (Month, Dey, Yaar)

32. Registrar's Signature

State Registrar

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Piease Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1_Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUL **Physician** ACKSON 3:50 PM ACQUELINE ANITA 99 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE HEALTH CARE AGNES If Under 24 Hrs. 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign Country)
ARY AND 7. Age (In yrs. last birthday) **Funeral** 10 M 21 F Days Months 66 218-28-6362 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County Od. Inside City Limits 28a-f show 1+ IMORE 1 □ Yes 2 □ No Director 10a, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 21244 516 234 THIAC MOAD AMES Funeral Herman. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 NNo If Yes, Give Year or Dates: 1 Never Merried 2 Merried 8 1 Yes 2 No Specify: Specify: (þ natural'. 3 Widowed 4 Workorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) EACHERS 13 Public is marked other permit. Pages 1 and 2 should be file Department of Health, and Mental Hy Important: If Nem 27 is marked oth any Injury or other traumatic event pace. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MARY ERBERT 2 ANCASTER LOOTE 19e. Informent's Name/Reletionship (Type, Print) Dayghtel 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) JAMES 3516 ST. JACKSON , 21244 140. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State MEM. BALLIMORE, Arbutus 4 ☐ Donetion 5 ☐ Other (Specify) CEM. 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility NUHER & DONS FUNERAL KOME nutter 2501 GWYNNIS FALLSPKWY BALto. 21216 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tellure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** EPIDURAL HEMATOMA /Medical ARGE Immediate Cause (Finel disease or condition resulting in deeth) Examiner Due to for as a consequence of URAL HEMATOMA Physician/Medical Examiner Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown FND MELLITUS signed b Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? NEUMONIA DISEASE completion of cause of death? FAILURE RESPIRATORY 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospitel: Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28c. tnjury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of After 1 Natural 5 Pending investigation 1 Yes 2 No hours after death. 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number JUL, 07, 1999 we soman

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aitimore, Maryland 21215-0020

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31. Dete filed (*Month*, *Dey*, *Year*) **JUL 1 3 1999**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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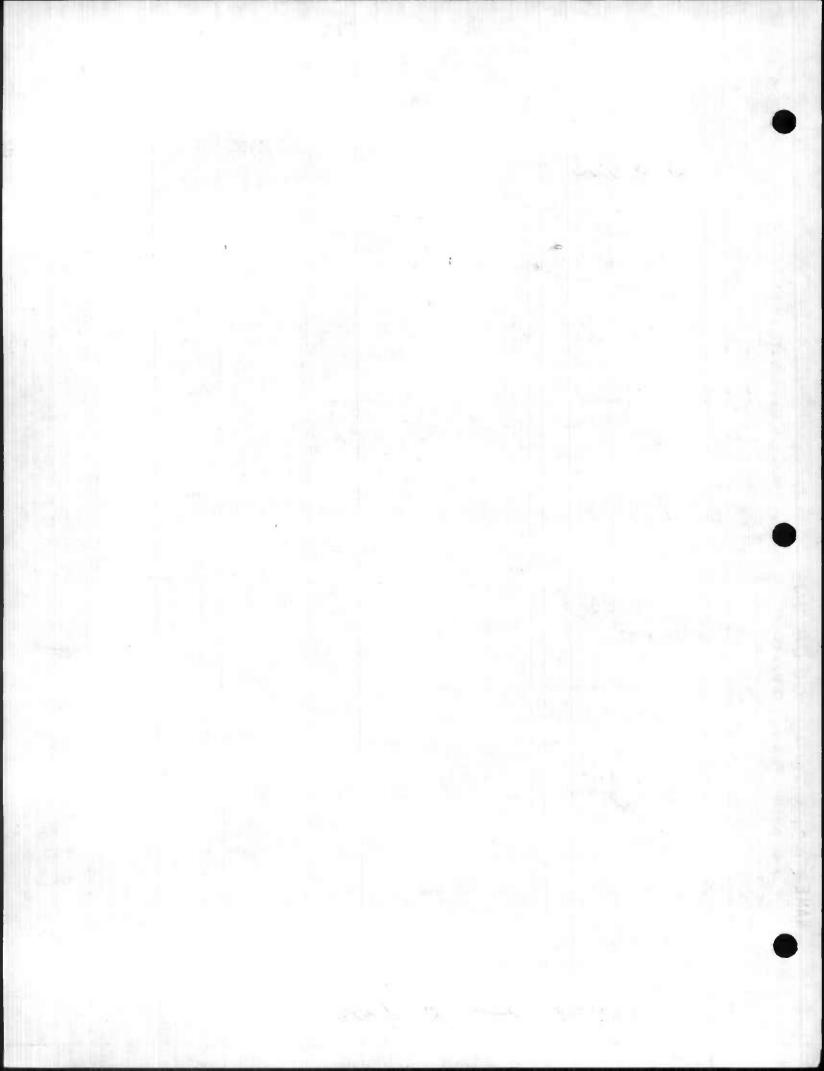
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ORIGINAL

900 CATON AVE BALTIMORE

mD 2/229



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Luast) **Physician** 02 h50m /Medical 4c. County of Death 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5 IN-Denison N Baltimole If Under 24 Hrs. 8. Date 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day) 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 20 F Months Hours 213 - 52-3366 Usual Residence of Decedent Yrs. Director MARY 10a State 10b County 10c City, Town or Location 10d. Inside City Limits r 28a-f show 1 Yes 2 No Director MORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Name 23a or 15 2 122 SON 1 Funeral Illed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Merital Stetus Black, White, etc. 1 Never Married 2 Merried 21215-0020 1□ Yes 219 No Specify: by Specify: (3 ☐ Widowed 4 ☐ Divorced Pages 1 and 2 should be Illed within 72 honen of Health and Mental Hygiene. Int: If Item 27 Is marked other than "naturury or other traumatic event, the Medical. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry BALTIMORE Elementary/Secondary (0-12) College (1-4or 5+) EACHER Public Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MAHhEWS FAE GREENE NK 19a. Informant's Name/Relationship (Type, Print) Dayghtel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AVE BAlto. M.D. 21229 ENISON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition permit. Pages Department of Important: If it eny Injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) DALTIMORE Cem. 19,1994 22. Name and Address of Facility Nutter Funeral Homes, INC. 21. Signature of Funeral Service Licens 2501 Gwynns Falls PKWY Baltimore, Md zrzib 23a. Part. Enter the disease, occomplications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata **Physician** /Medical Immediate Causa (Final disease or condition resulting in death) Examiner Physician/Medical Examine The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury as a consequence of) Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ of Vital Records, 24b. Wera autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 1 No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) 28 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural 2 Accident 5 Pending investigation death. 1 Yes 2 No 24 hours after deat Funeral Director: 6 Could not be determined 3 C Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certitier (Check only one) within 2 the th 29b. Signature and title of certifier

State Registrar

DHMH 16 Rev 6/95

Johnson

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

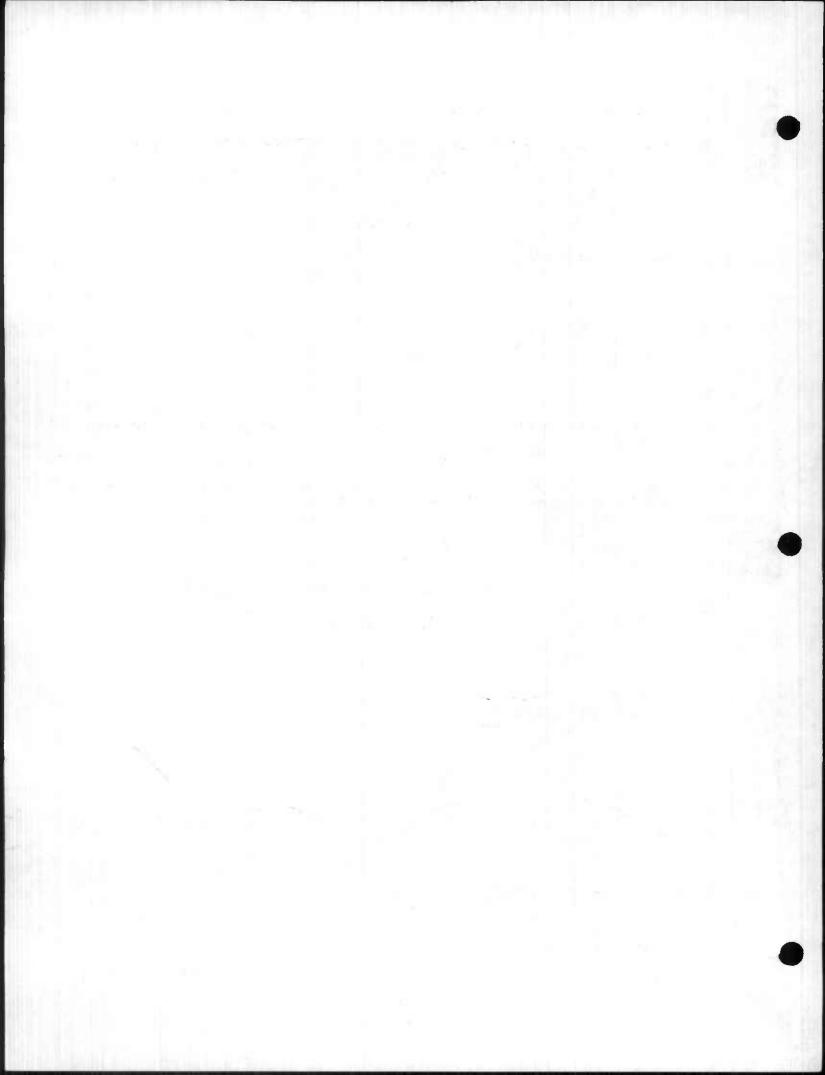
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31. Date filed (Month, Day, Year)

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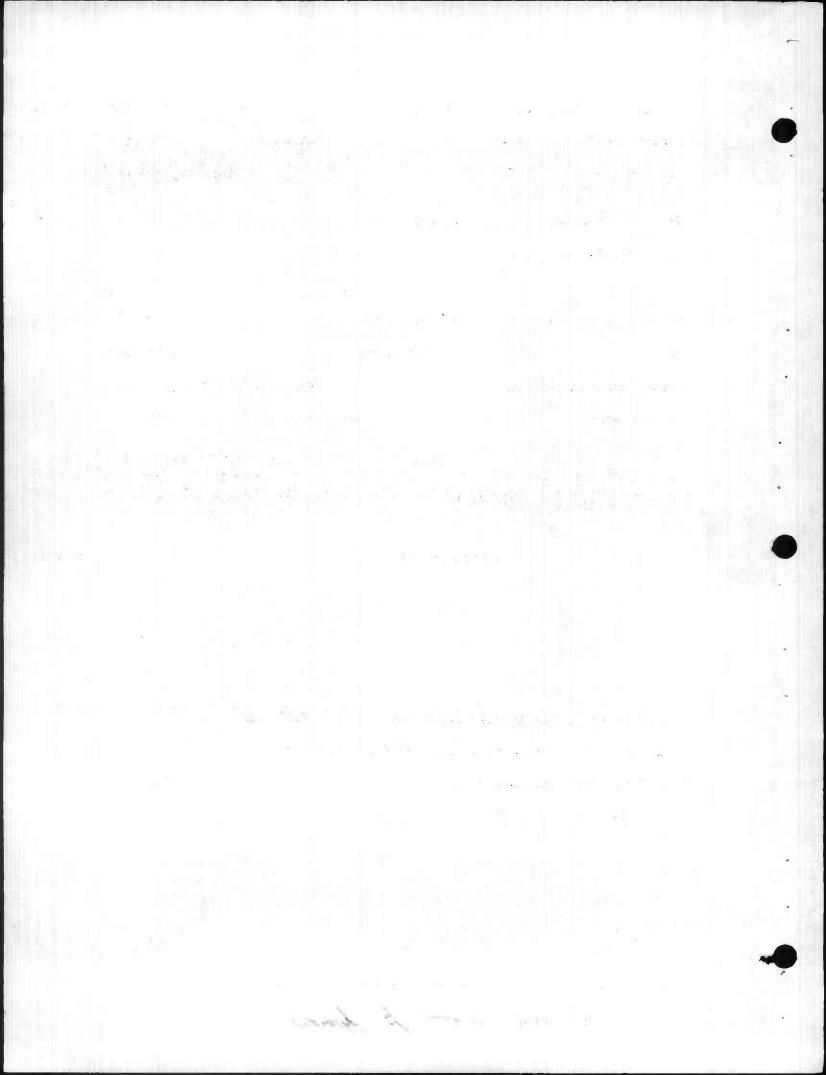
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5-0020	s 1 and 2 should be filed within 72 hours efter death with the Maryland I Health and Mentel Hygiene. I Health and Mentel Hygiene. It is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Eventher must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ N 3 ☑ Widowed 4 ☐ Divorce	larried Arme	Decedent ed Forces? Yes 2 X s, Give or Dates:		'	Wes Decedent of Information of Info	dispanto Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Bla	ce - Americk, White,	
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lon	Attending For death. Octor: After by the funer	ation	Netural 5 Pen 2 Accident Inve		Month, Da	y Year)	njury	28c. Inju Wo M 1	rk? Yes 2□No		,,,,		
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	with:	Σ	29b. Signature and title of cert	Tune	R			29c. Licens	39127	7	29d. Date signe 7/6 /	ed (Month,	Day, Year)
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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Kolodziej JOHN EDWARD 3:30pm · /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner BALTIMORE MARIS STELL 8. Date of Birth (Month, Day 04-24) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1**X**M 2□ F Months Days Hours Min 203.32.076 Yrs. Director 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be illed within 72 hours efter death with the Marylen Department of Haalith and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any Injury or other traumatic event, the Marical Examine ment has notified any injury or other traumatic event, the Marical Examine ment has notified a Cockeysville, MD 1 Yes 2 No BACTIMORE MD Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 21030 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 PYes 2□ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SELF-EMPLOYED 18. Mother's Neme (First, Middle, Maiden Sumame) olodzie) 17. Father's Name (First, Middle, Last) DOROthy JOHN KOLODZIEJ JMIT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/63 19a. Informant's Name/Relationship (Type, Print) SPOUS 318 LIMESTONE VALLEY RO. 318, Cockeysulle MD LINDA KOlodziei 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility asol 3a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory show or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner as a consequence of) Examiner physician and the burial-transit certificate be assecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as e consequence of): Se been signed by the atte should be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 2016 1 Tes 1 Tyes this certificate i or Attending Physician: after death. Director: After this certifica 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation Natural 1 Tes 2 No 2 Accident 6 Could not be 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D Contifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29d. Date signed (Month Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) 13

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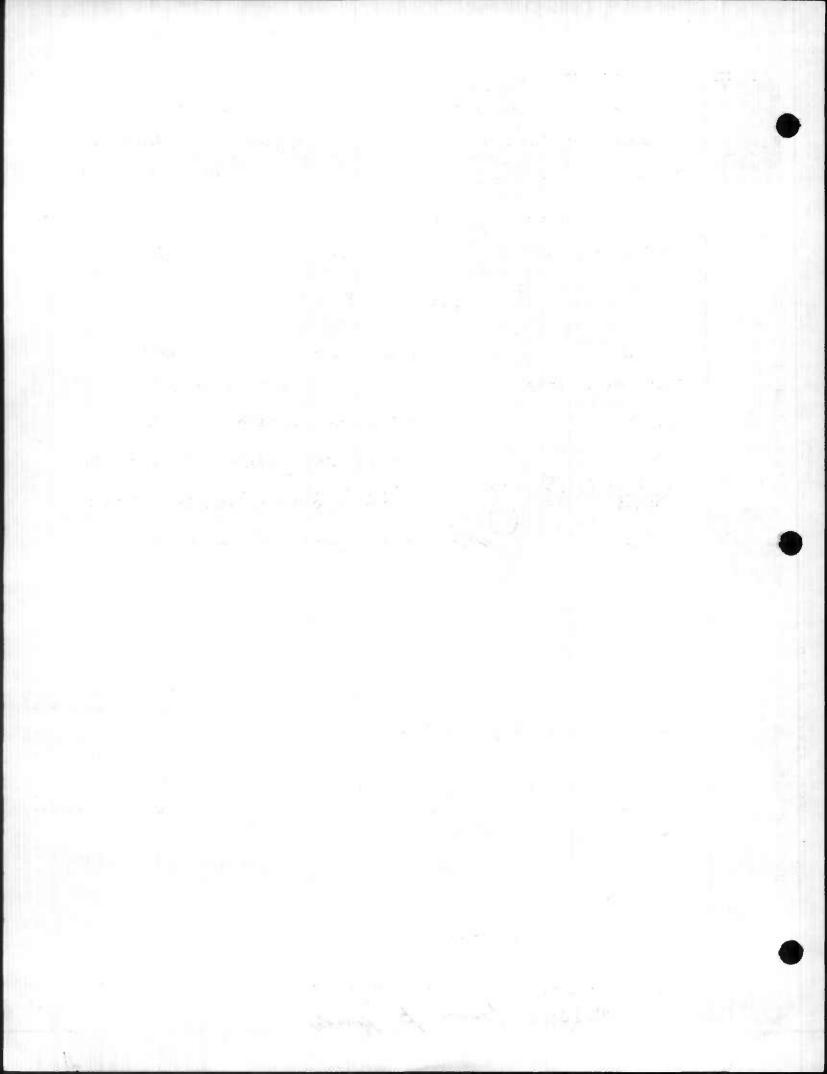
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Funeral		Social Security Number 6. S		(in yrs. ias	t birthday)	If Undar 1 \	Yaar If Undar 24	Hrs. 8. Date of	Birth			
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ylan		10a. State 10b. County		10c. City, 1	own or Loc	ation				10	d. Inside City Limit	
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ifter deeth v	e	11. Marital Status	12. Was Decedant Ev Armed Forces?	ver in U,S.	13. W	as Deceden	t of Hispanic Origin Cuban, Mexicen, F	? (Specify Yas or	No- 14. Rad	ce - Amarica		
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1 and 2 Health 1 em 27 ls		John Jeppi			9 B	uchana	an Rd.,	Balto.,	MD 21212			
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To the compla	1	29b. Signature and title of certifier	1.1.1	22			icense number		29d. Date signe	d (Month, D	Day, Year)	
		1 Sec.	064/4				/ 155	07	7-6-99			
		30. Neme end address of person who	completed cause of dee	eth (Item 23	Ba) (Type, P	rint)						
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State		Eddie Nakhuda 31. Date filed (Month, Day, Year)	M D 32. Registrer	's Signature	a			4/4 11	m0111.UIII.,	ra a Z	1037	
Registrar	-	JUL 131	999	war	4	Spo						
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KENNY, MSGR. SIMON EDWARD



Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#29c perVerbal MD G773 7/13/99 EW 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 11:00 AM JOHN KENDALL JULY 08 1999 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE GIY BALTIMORE HARBOR HOSPITAL CENTER If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 100 M 2□ F Days Months 52 218-46-2315 Yrs. NOVEMBER 25/1946 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Ann Arundel Pasadena 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8042 Abbey Court 21122 USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Maritei Status 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Security Guard Shipping 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ralph J. Kendall Wanda Komorowsi 19a. informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3200 Juneau Place, Baltimore, Diana N. Kendall-Sister Md 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 7-10-99 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck Funeral Home Inc. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hearthfullure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final STAPHYLO COCCAL SEPTIC 2 DAYS disease or condition resulting in death) Due to (or as a consequence of): LOWER RIGHT Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): CELLULITIS LEG RIGHT LOWER Due to (or es e consequence of): STAPHYLO COCCAL SEPTICEMIA Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Mellitus

Physician /Medical Examiner

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked ortherny injury or other treumatic event once.

Physician

/Medical

Examiner

Funeral

Director

rai', or items 23s or 28s-f show Examiner must be notified at

natural, or

filed within 72 hours after

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Records,

Division of Vital

or Attending Physician:

Hospital

After

death.

24 hours after deal Funeral Director:

within 2 8

DHMH 16 Rev 6/95

filled in by

Director

Funeral

Completed

Examiner Physician/Medical by Completed 8 Certification: To funaral

Chronic Renal Failure Congestive Heart failure

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?
1 Yes 2 No

Hospital: 1 Inpatient 2 □ EFVOutpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manger of Death 1 Neturel 2 Accident 3 ☐ Suicide

4 Homicide

5 Pending Investigation 6 Could not be determined

28c. injury at Work? 1 Yes 2 No 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

281. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signeture end title of certifier eando. 29c. License number RES-000

JULY / 08

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

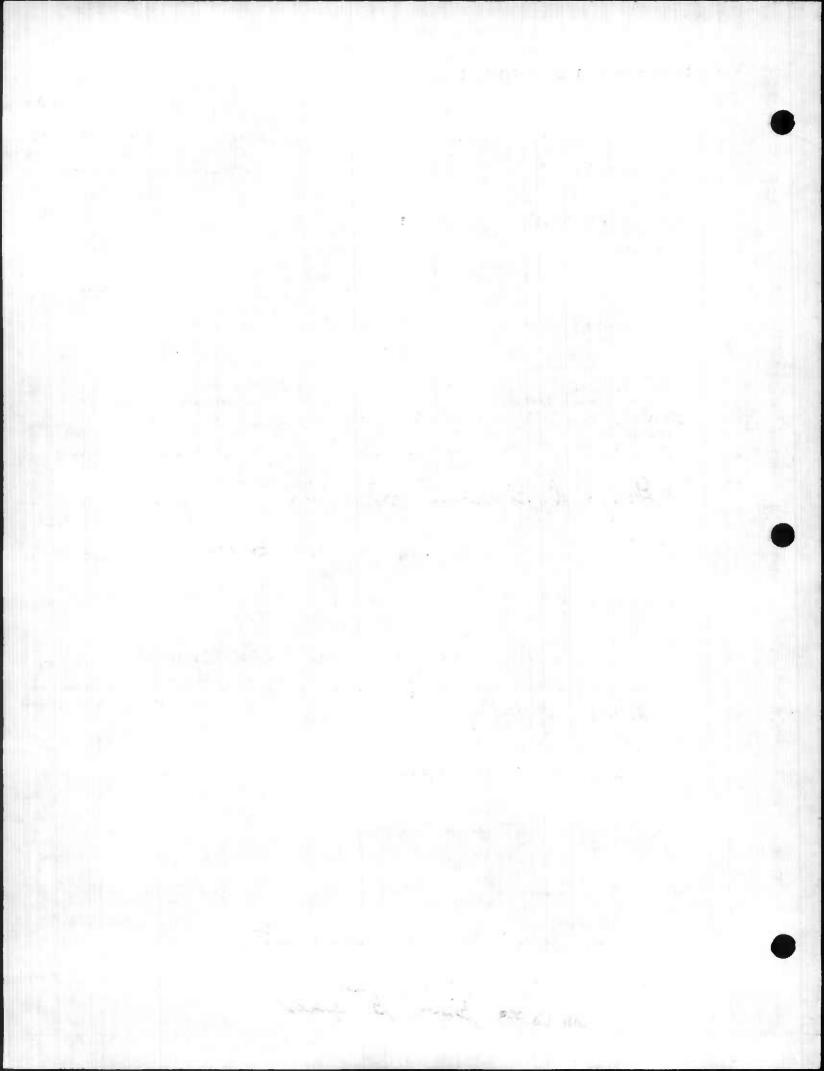
1.3 1995

DORJEE ISHERING 32. Registrar Signature 31. Dete filed (Month, Day, Year)

AMDO, 6920 Donoshie Road, #909, Ballimon, MD 21239

State Registrar

edicai



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Death 3. Time of Death 07-Day 99 Anthony J. Kikola 1:33 AM 4a Facility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Hopkins Bayview Baltimore N/A If Under 24 Hrs. If Under 1 Yeer 8. Date of Birth Month, Day, Year! 09-20-15 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2□ F Months Days Hours 83 213-07-4460 MD Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits NO Yes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 USA 244 S. Clinton St. 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2F No If Yes, Give* Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Stetua 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 ☐ No Specify: SpecWHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Foreman 0 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Josphine Lzielwska Walter Kikola 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 244 S. Clinton Street, Balto., MD 21224 Theresa Kikola 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta Buriel 2 Cremetion 3 Removel from Stete Sacred Heart of Jesus7-10-99 Balto., 21. Signature of Funeral Service License 22. Name and Address of Facility Kaczorowski F.H. Dundalk Avenue, Ba 21222 Balto., plications that caused the a Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURF Sequentially list conditiona, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2ER/Outpatient 3□ DOA 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturel 5 Pending Investigation 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

re 23a or

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filed within 72 hours after

Hygiene

Pages 1 and 2 should be nent of Health and Mental

of Health a

Department of Important: If any Injury or

Baltimore, Maryland 21215-0020

Director

Funeral

p

Completed

MD

use as the burial-tran

Completed by Physician/Medical Examiner After this certificate has funeral director, Be Medical Certification: To

the

filled in by

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending

To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A

State Registrar 29b. Signature and title of cepifier

6 Could not be determined

2 Accident

3 ☐ Suicide

29a. Certifier (Check only

4 ☐ Homicide

29c. License number

JC Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. 29d. Date signed (Month, Day, Year)

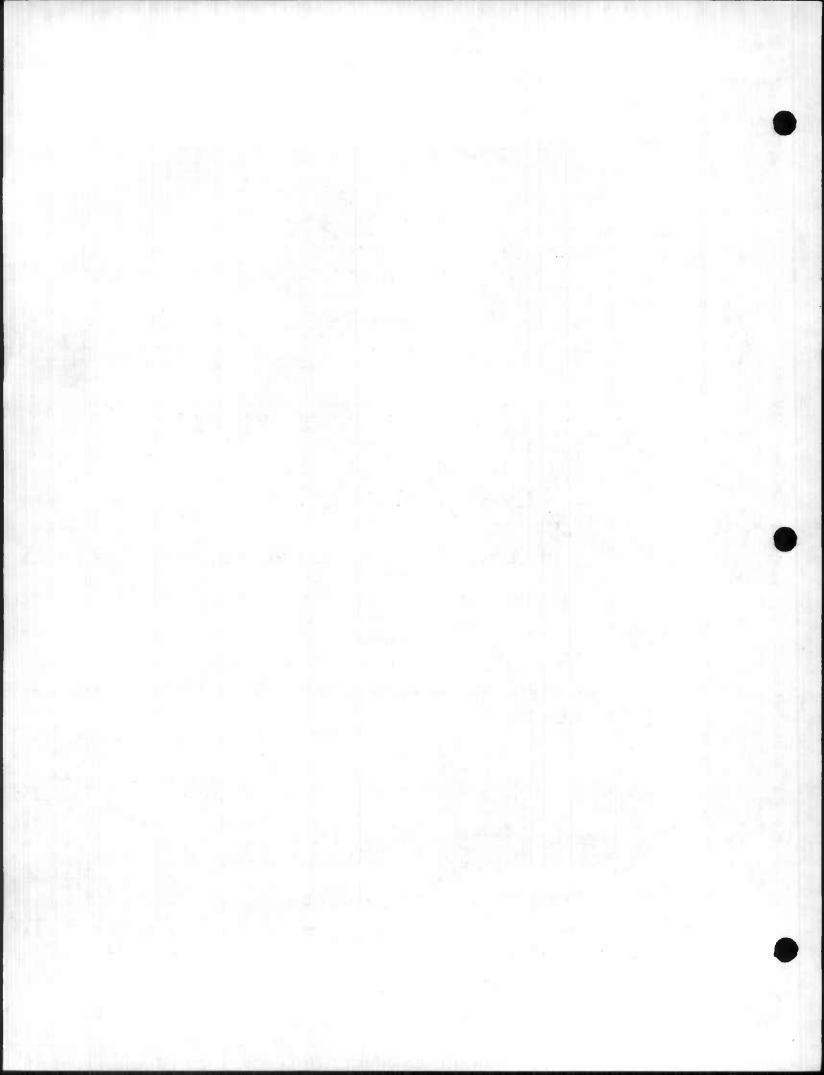
28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

31. Dete filed (Month, Dey, Year) 32. Registrar's Signature 3 1999

DHMH 16 Rev 6/95

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth Month Day BLANCHE V. KONENCY JULY 9 1999 9:51 A.M. 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth GILCREST HOSPICE TOWSON BALTIMORE If Linder 1 Year If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Months Deys 1 □ M 2 😿 F Yrs 219-18-0853 78 8/29/20 MARYLAND Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE HILLENDALE 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 8126 RIDGELY OAK ROAD 21234 USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify 3X Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 4 YEARS NURSE HOSPITAL 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) MICHAEL GREENHOOD AMELIA SCHUHART

se filed within tal Hygiene. permit. Pages 1 and 2 should be Department of Health end Menta Important: If item 27 is marked on any injury or other traumatic ev Pages 1 and 2 nent of Health

Physician Examiner

Physician

/Medicai

Examiner

10e Stete

MD

19a. tnforment's Neme/Reletionship (Type, Print)

1 Surial 2 ☐ Cremetion 3 ☐ Removal from State

War

BARBARA MCGARVEY

4 ☐ Donetion 5 ☐ Other (Specify)

21. Signeture of Funeral Service Lice

31. Dete filed (Month, Dey, Year

1 3 1999

20e. Method of Disposition

Funeral

Director

rai', or items 23a or 28a-f shov Examiner must be notified at

Directo

Funeral

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Be

the Marylend show

and After or Attendination after death. e Hospital of 24 hours a To the F within 2

of Vital Records. Division

Konency

State Registrar

Interval Between Onset end Death Immediete Ceuse (Final diseese or condition resulting in death) . CONGESTIVE MEMRT FAILVRE Due to (or es e consequence of):

CARDIOM NO PATHY

Due to (or es e consequence of): Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest MYOCARDIAL INFARCTION Physician/Medicai Pert II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Pert t. 1 ☐ Yes 2 ☐ No 3 robably 4 Unknown MELLITUS DIMBETES þ 24b. Wera autopsy findings eveilable prior to comptetion of ceuse of deeth? 24a. Wes an eutopsy performed? Completed 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicat examiner?
1 ☐ Yes 2 ☐ No Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 HOther (Specify) HO HICE 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth Certification: 28e. Dete of Injury (Month, Dev Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner stated. 29b. Signature end title of certifier

20b. Plece of Disposition (Name of cemetery, cremetory or other plece)

MORELAND MEMORIAL PK.

22. Name end Address of Fecility

23b. Did tobacco use contribute to the cause of death?

20c. Location - City or Town, Stete

7/12/99 HILLENDALE, MD

29c. License number 29d. Dete signed (Month, Day, Year)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)

8126 RIDGELY OAK ROAD BALTIMORE, MD

THE JOHNSON FUNERAL HOME, P.A.

o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, MD 21286 Approximate only one cause on each line.

030433

N'CHARLES STREET

BALTIMORE

6701

32. Registrer's Signature

ed cause of deeth (Item 23e) (Type, Print)

DAUGHTER

Market and Andrews

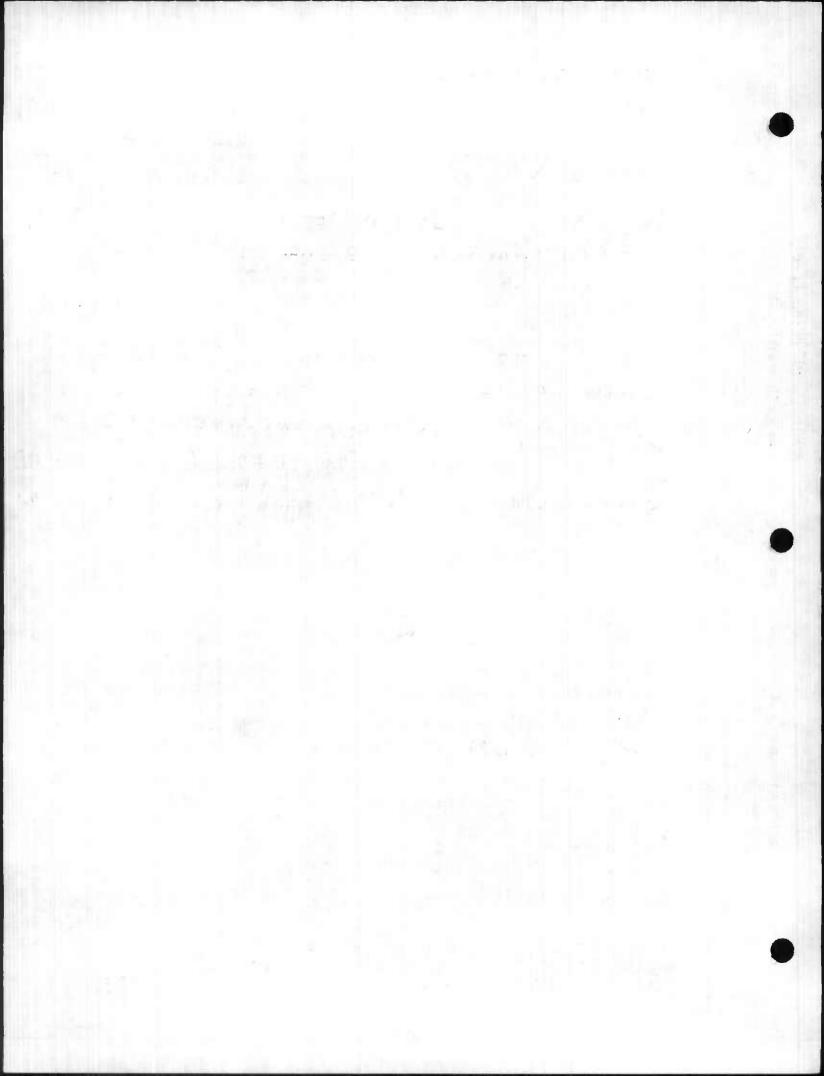
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

KNOWN as ARTHUR LEWIS

DHMH 16 Rev 6/95

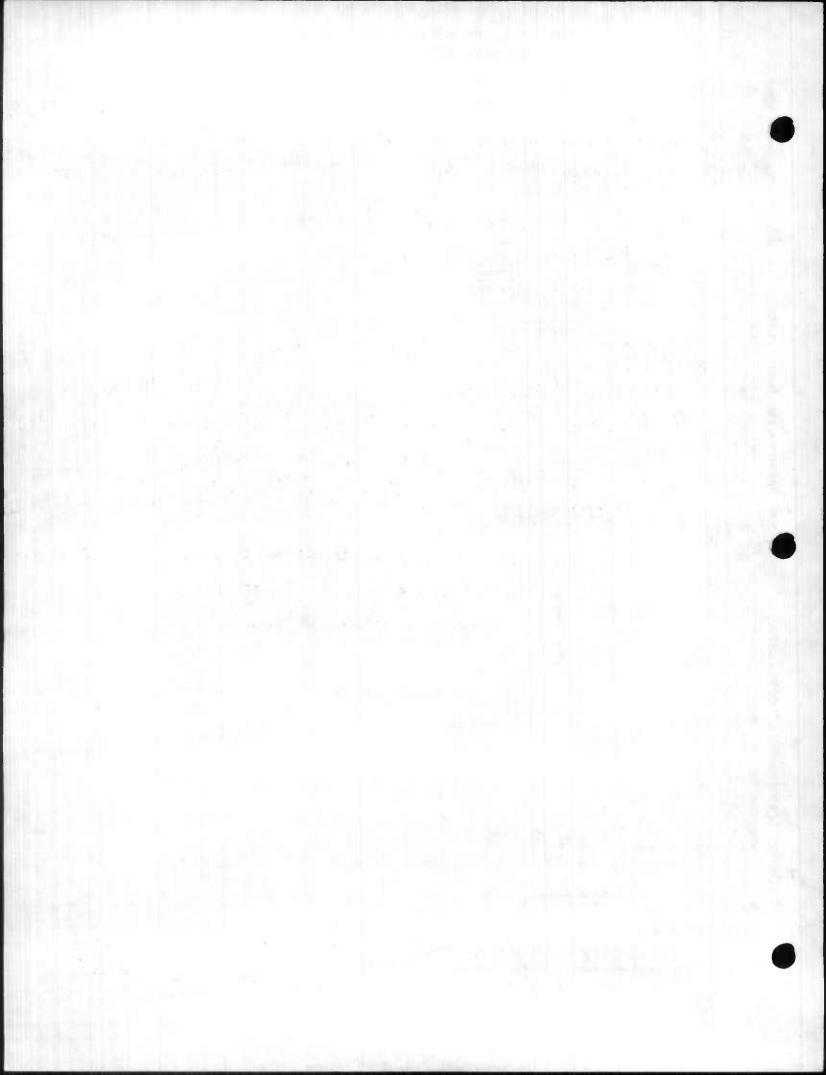
State Registrar

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1) Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Data of Daath 3. Tima of Death **Physician** 999 130 JUY INWOOD /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner NIA HOSPITAL 8. Date of Birth Month, Dey, Yeer, A.N. 3, 1930 If Undar 1 Yaar 7. Age (In yrs. last birthdey) Birthplaca (State or Foreign Gountry) 5. Sociel Security Number **Funeral** 10M 20 F Months Days Hours Min 229-34-404 9 Director VIRGINIA Usual Residence of Decadent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other treumstic event, the Medical Examinet must be notified at BAltimoRE 1 Yas 2 No Directo Atonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5 9199 100 ROS MOAD Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☑ Yas 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Item 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced IACK Completed 18a. Decedent's Usuel Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highast grada complated) Elementary/Secondery (0-12) College (1-4or 5+) FIBC ontractor 18. Mother's Name (First, Middle, Maiden 17. Fether's Neme (First, Middle, Last) Be 0 buy lorid 001 INWOOD 19a. Informant's Name/Ralationship (Type, Print) FIANCE E 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Rd. DO BROWN ROSby IDIA to. 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State ò NWALDOO CEMETERY 13,1999 any injury once. 4 Donation 5 Other (Specify) DALTIMORE 22. Name and Address of Fecility Nutters Sons FUNERAL HOME 21. Signatura of Funeral Service Licensee 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, abock, or fraan failure. List only one cause on each line. Balto. M.D. 21216 Approximate Intarval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disaese or condition resulting in death) Meningiti Examiner Due to (or es a consequence of): Examiner Imunodeficence tequired ettending physician and for use es the buriel-tran Sequentially list conditions, if any, leading to immediate causa. Enter Undarlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) certificate be exer Box 68760. Physician/Medicai Dua to (or as e consequence of) BS Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No Decubitus by 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? Completed completion of cause of death? hes pege 2 -ash 1e11 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificete 25. Was case referred to medical examiner? Be 28. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 10 1 Yas 2 No 1 Sinpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this 28a. Date of Injury (Month, Dey Year) funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. tnjury at Work? Certification: 1 Natural 5 Pending investigation 2 No 1 Yes 2 Accident efter deeth Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours of To the Funeral I edical 29a. Certifier 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and mannar stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number MO 30. Name and address of person who completed cause of deeth (item 23a) (Type, Print) 900 Caton mo. Agnes Hospito Connac 51 31. Dete fited (Month, Day, Yeer) 32. Registrer's Signeture State JUL 131999 Registrar **DHMH 16 Rev 6/95**

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month **Physician** 6:55 10 Mary /Medical 4b. City, Town, or Location of Dea 4a Facility Name (If not institution, give street and number) 4c. County of Dea Examiner losthwest Hospital centien 5401 old Court Rd Randalstown If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) If Under 1 Yaar 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Months Deys 57 1 M 2 F - 26 - 839 Yrs. Director Usual Residence of Decedent death with the Meryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show File marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examiner must be northed at 1 Yes 2 No Maryland aW Director 10f. Zip Code 10e. Straat and Number 10g. Citizen of What Country? lames Funeral 12. Was Decadant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Marital Stetus Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If itsm 27 le marked other than "naturel", or ite eny injury or other traumatic event, the Medical Examina 1 Yas 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 (No Specify: AFFO à 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working)
life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) OX 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sugname) (Son 19b. Malling Address (Ştreet and Number or Rural Routa Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of confidence) crematory or other place) are to. ughlina x Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 □Removal from Stata 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signat Josep W. NOr Ave. the seese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or many hiture. List only one cause on each line. Approximate Interval Between Onsat and Death respiratory **Physician** /Medical Immediate Ceuse (Final disease or condition resulting In death) 4 45 Examiner Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last ce of) Curgestice to Division of Vital Records, P.O. Box 68760, 98 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. the a 1 Yes 2 No 3 Probably 4 Unknown 6 þ 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed peen s completion of cause of death? has certificate ! 28 No 1 Yes 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4☐ Nursing Homa 5☐ Residenca 6☐ Other (Specify) 70 1□ Yes 2□No 3□ DOA 1 ☐ Inpatient 2 ☐ ER/Outpatlent within 24 hours effer death. To the Funeral Director: After this funeral 28b. Time of 28d. Dascribe how Injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 Tes 2 🗆 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated. edical (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end placa, and due to the cause(s) and mannar stated. the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who comp ted cause of death (Item 23a) (Type, Print) 1COON Centre Assitue Northwest 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death JULY 3 Day **Physician** 1-40 An WANDA MARCH /Medical 4a Facility Name (If not institution, give street and number)

NORTH ARVNDEL 4b. City, Town, or Location of Death 4c. County of Deeth Examiner HOSPITAL GLENBURNDE ATTOKE # Under 1 Year | # Under 24 Hrs. | 8. Dete of Birth | Months | Days | Hours | Min. | A TRIL 16 1927 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign KY ountry) **Funeral** 1□M 2√2 F 401-30-2945 Director Usual Residence of Decedent 10s. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show MD Anne Arundel Glen Burnie 1 Tyes 2K No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ŏ 1627 Tieman Drive 21061 **USA** Berns 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Merried 2 Married Specify White Saltimore, Maryland 21215-0020 1 Ves 2 No Specify: "natural", or þ 3 ☐ Widowed 4 ☐ Divorced i Hygians. Other than "nature ent, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind ot Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked other any Injury or other traumatic event. 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) WOOTEN HTRAM MARTHA NAPTER 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Gordon W March Sr. (Husband) 1627 Tieman Drive, Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, cremetory or other place) Cedar Hill Cemetery 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removat from State Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Charlton Dean F Charlton

2007 Eastern Ave, Baltimore, MD 21231

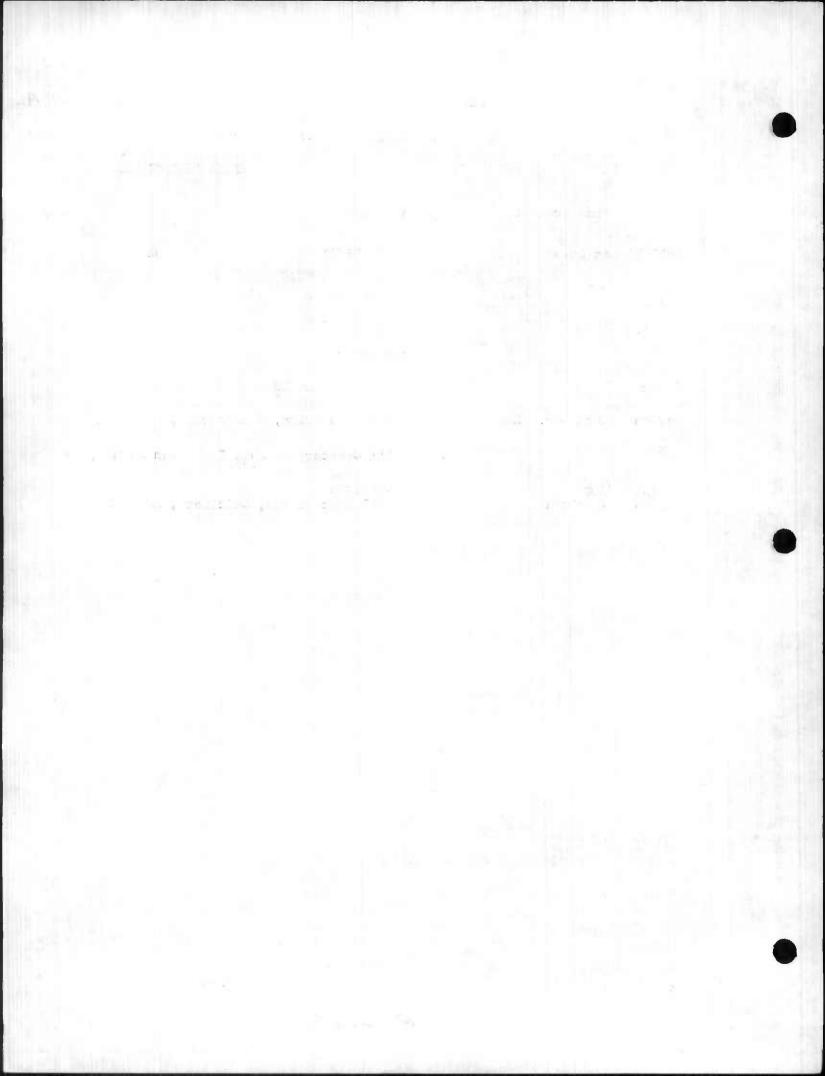
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finet disease or condition resulting in death) SEPSIS Examiner Physician/Medical Examiner OHRON IC RENAL

Due to (or as a consequence of): FAILURE ettending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or thjury that initiated events resulting in death) Last Records, P.O. Box 68760, DIADETES MELL Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? page 2 s 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medicat examiner? Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 Alo Hospital: 1 Nnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Natural Division 5 Pending investigation or Attending s effector: After V the fr 1 Yes 2 No 2 Accident 28t. Location (Street end Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 124 hours effer to Funeral Direct plataty filled in b 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 hos To the Fune completely fi (Check only one) 29c. License number 15 1664 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUDHIR KUMPK ASCARNAL MD 2 1061 NORTH ARVNDEL HOSPITAL, 301 HUSPITAL DRIVE, GLEN BURNIE, MD 2 1061 31. Dete fited (Month, Day, Year) 32. Flogutrar's Signeture State JUL 13 1999 Registrar

DHMH 16 Rev 6/95

2

& Anda



The law requires that the death certificate be executed Physician: Division Attending

use es the burial-trar physician for 6 90 page 2 should certificate hes this Affer To the Hospital or Attendii within 24 hours efter death. To the Funeral Director: A filled in by completely

Physician/Medical Examiner ģ Completed Be 2 Certification:

Physician

/Medical

Examiner

Funeral

Director

must be notified at

r than "natural", or itam the Medical Examiner. filed within 72 hours efter

Hygiene.

Peges 1 and 2 should be nent of Health and Mental

of Heelth and Menta item 27 is marked other traumatic en

nt of Heelth a H item 27 is or other tra

Department of Important: If any Injury or

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21215-0020

Maryland

Saltimore.

1 Natural

2 X Accident

3 Suicide

4 - Homicide

(Check only

John T.

29b. Signeture and title of certifier

Medical

State Registrar

31. Data filed (Month, Day, Year) JUL 1 3 1999

Bulkeley,

30. Nema end addrass of parson who complated cause of death (Itam 23a) (Type, Print)

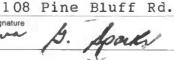
5 Pending investigation

6 Could not be determined



M.D.

uleste



29c. License number

DME 0003599

1 Yas 2 No

2301

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Coastal Highway - 123rd St.

1 Cartifying Physicien: To the bast of my knowledge, daath occurred et the tima, data and plece, and dua to the cause(s) end mennar es stated.

Madical Examinar: On the basts of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Year)

Pedestrian struck by car

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

7-7-99

Ocean City, Md.

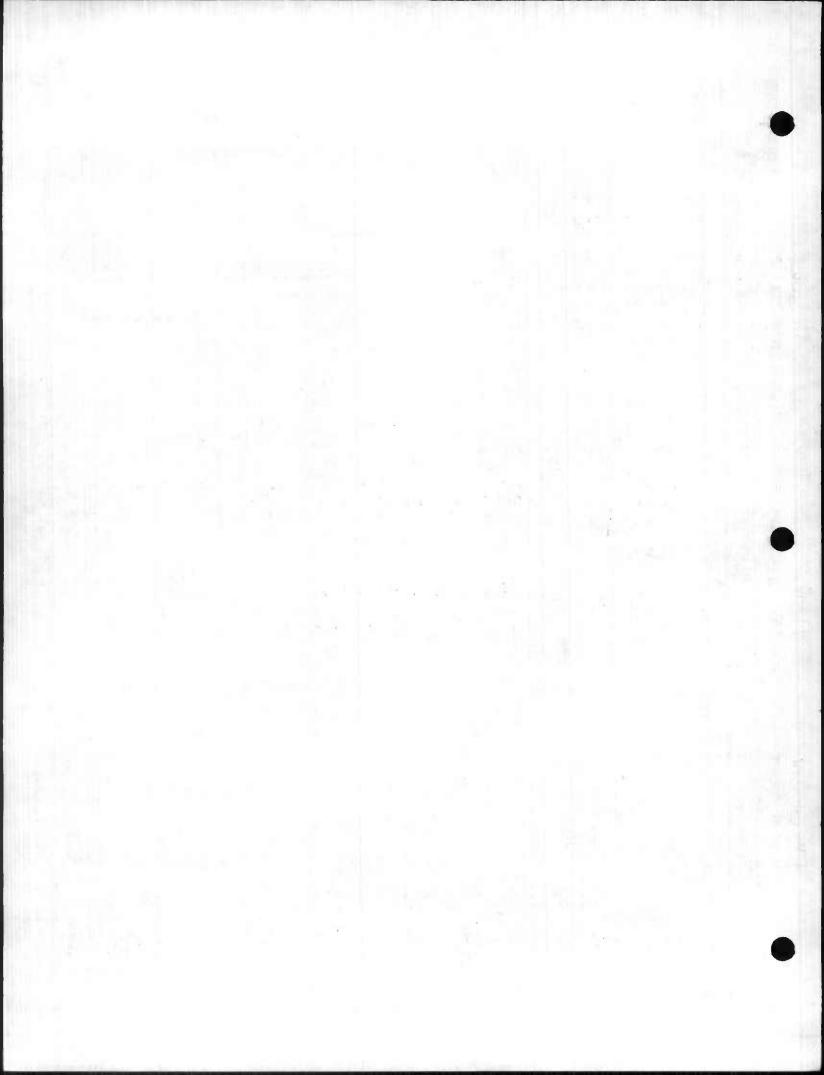
Salisbury, Md.

21801

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		State of Maryla	•	artment of rtificate or			giene 9	9 8	21918
Physician	Decedent'a Name (First, Middle, Last, EUGENE MCCALL)				2. Dete of Dea Month JULY	Day	Year 999	3. Time of Death 23:10
/Medical Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, o	Location of Death			23:10
Examine	HARFORD MEMORIAL	HOSPITAL			HAVRE D	E GRACE	HARI	FORD	CO
Funeral Director	091-24-7238	XM 2DE	s. last birthday) 69 Yrs.	If Under 1 Yea Months Dey		1. (Month, Da	y, Year) 23 1930	9. Birthpl Count FLOF	aca (State or Foreign ry) RIDA
pu Mary	Usuel Residence of Decedent 10e. Stete 10b. County	10c. C	City, Town or Lo	cation				10	od. Inside City Limits
the Maryla 284-f sho politied at ector	MARYLAND HARFORD	CO	EDGEW	OOD					1 ☐ Yes 2XXVIo
with the Ma t or 28s-f a be notified Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Count	try?
	331 WINTERBERRY				1040		U.S.A.		
020 urs after death v if, or herra 23 caminer must by Funeral	11. Meritel Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes ②XNo If Yes, Give Yeer or Detes:		Was Decedent of f Yes, specify Cu	Hispanic Origin? (ban, Mexican, Pue o Specify:	Specify Yes or No- into Rican, etc.)	14. Race Black Specify:	- America K, White, &	etc.
1 21215-0020 sed within 72 hours at bytiens at bytiens at bytiens when then "centural", or mut, the Medical Exams Completed by F	15. Decedent's Edu (Specify only highest grad	e completed)	16a. Deced	dent's Usuel Occ kind of work don DO NOT use retir	upation e during most of w red)	orking	16b. Kind of Bus	siness/Ind	ustry
212 Grand and Month	8th grade	College (1-4or 5+)	JAI	NITORIAL			GOVER	NMENT	
E 225 9	17. Father's Neme (First, Middle, Last)				t 8. Mother's No	ame (First, Middle,	Maiden Sumame)	
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Man and 2 st and and 27 to an	19a. Informent's Neme/Relationship (Ty Mattie Graham/Fr				et and Number or Nerry Dri				
Te, Tean other other	20e. Method of Disposition	20b.	Plece of Dispo	sition (Neme of netory or other p	-	Dete	20c. Location - (4	
altimo altimo mit. Pape partment o sortant: it i	1 ☐ urial 2 ☐ Cremation 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)			ILLS CEM		7-15-99	MIDDLE H	RIVEF	R, MARYLAND
Baltimore, permit. Pages 1 at permit. Pages 1 at permit of the proportant if them? any injury or other strice.	21. Signature of Funeral Service License	Blown	1		ress of Fecility C BROWN ORTH AVE		FUNERA	L HOM	IE-HARFORD PA
Sx 68760, certificate be executed refined physician and use as the burial-transit and use as the	23a. Pert1. Enter the disease, or complishock, or heert feilure. List only or immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last	Due to	(or as a conseq of as a conseq of the aconseq (or the aconseq	wa juence of): under oth	V Jasix				Interval Batween Onset end Deeth
ontific certific certific pure as	L.							1	
O. B or death the and the for hed for	Part II. Other significant conditions con	stributing to death but not re	esulting In the u	nderlying cause (given in Pert I.	23b. Dtd (obacco use con	tribute te	the cause of death?
						10	Yas 2 No	3 Prot	ably 4 Unknown
Di se di di						24a. Wes perio	en eutopsy rmed?	ave	re autopsy findings illable prior to inpletion of cause death?
Con the same of th						101	res 20No	10	Yes 2□ No
W, Eugh	25. Wes case referred to medical examiner?	lospitel:				eeth (Check only o	ne)		
2 2 2 2	1 Yes 2 No	1 Linpatient 21	☐ ER/Outpatier 28b. Time of	I 3LI DOA		Home 5 ☐ Resid	dence 6 Othe		")
Division or Attending after death. Director: After tun by the tun entification	1 Neturel 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Dete of Injury (Month, Day Year) 28a. Pleca of Injury - At building, etc. (Spec	home, ferm, str	M 1	☐ Yes 2 ☐ No		Street and Number		l Route Number,
No Hospital	29e. Certifier 1 Certifying Physical Check only 2 Medical Examinates	nician: To the best of my kr ner: On the basis of examination of menner steted.	nowledge, death netion end/or inv	occurred et the restigation, in my	time, date and place opinion, deeth occ	ce, end due to the	cause(s) and mar date and placa, a	ner as st nd due to	ated. the cause(s)
To the complete of the Mec	28b. Signaturi and title of certifier	MP		25c Lice	nse number	1	29d. Date signed	Quanth, I	99
State	30. Name analogues of person who co	ofpleted cliuse of death (No.) 32. Registrac's Sign	Haur	redo	Grace	MD:2	6078	5	[LEEMD



ENDED ITEM	#26			Н	naryland		riment of t	Death		Reg. No.	9	21919
Physic		1. Decedent's Nem		oc IN	7-9	RE	-		2. Dete of De Month	Dey 12	Yaer /975	3. Time of Deeth
/Medi Examir			If not institution, giv	re street and number	r)	, , , ,		4b. City, Town, or	-		-	6.1
Funeral Director		5. Social Security N 216 20	Number 6. S	Sex 7. A		est birthday) Yrs.	If Undar 1 Yaar Months Days		. (Month, D	rth ey, Year)	Coun	pleca (Stata or Foreign
		Usuel Residence o	f Decedant						W 31	(() ()	Maly	Tanu
show	2	10a. Stete	10b. County		10c. City	, Town or Loc					1	0d. Inside City Limits 1⊠ Yes 2□ No
the Maryla 28a-f shorn	Director	M D 10e. Street and Nu	n/a			Balt	imore			10g. Citizen of	What Coun	
3a or			llwood	Avenue			2122	4		US		uyı
within 72 hours after death with the Maryland ene. ene. than "natural", or items 23a or 28a-4 show than "modical Examiner must be notified at	by Funeral	11. Marital Status	ried 2 Married	12. Wes Decedent Armed Forces 1 X Yes 2 If Yes, Give Yeer or Detes:		y 13. W		Hispenic Orlgin? (ben, Mexican, Pue	Specify Yas or N rto Rican, etc.)		ce - Americ ck, Whita,	
Maryland 21215-0020 d2 should be filed within 72 hours aft the and Mentel Hygiene. The marked other than "natural", or traumatic event, the Modical Emilia	Completed	(Spec	15. Decedent's Ecity only highest gra		5+)			pation during most of wo	orking	16b. Kind of B		
e filed with the other the	Cor	12th 17. Fethar's Neme	/First Middle Last	1		Off	ice Man		oma (First Middle	Baltim Maiden Sumen		Contracting
and de filec	Be C		C. McInt						e Gardne		ne)	
Maryland d 2 should be f th end Mentel I 7 Is marked of traumetic eve	Ţ		eme/Reletionship (on	19b. Meiling	Address (Stree	t end Number or F			State, Zip	Code)
M and 2 alth e 27 le		Pat McIr	ntyre			114 1	N. Ellwo	od Ave.,	Baltime	ore Mary	land	21224
Baltimore, M permit. Pages 1 and 2 Depertment of Health important: if than 27 It any Injury or other transcene.			•	Removel from State	a ce	ece of Dispos ametary, crem klawn	ition (Neme of etory or other pla	ace)	Date 7/15/99	20c. Location - Baltimo		own, State Maryland
Balt permit. Depertitions any inj			unerel Service Licer				Name end Addr	ess of Fecility Jakling St				,Funeral Hm
Physician /Medical		23e. ert1. Enter t shock, or hea	art feilure. List only (Finel	plications thet cause one cause on each	line.	Do not ente		lng, such es cardie	ac or respiretory (errest,		Approximete Interval Between Onset end Deeth
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68760, filcata be executed physician and as the buriel-transit	edical Examiner	Sequentially list co if any, laading to in cause. Enter Unde Cause (Disease or that initiated events	nditions, nmediata erlying Injury	C	•	es e consequ					1	
Box 68 eath certificat ettending phy for use as the	Physician/Medi	resulting in deeth)	Last	d	Due to (or	es a consequ	ence or):					
O. B.	sicla	Pert II. Other eignif	icant conditions c	ontributing to death I	but not resul	Iting In the un-	derlying cause gi	iven in Pert I.	23b. Dld	tobacco use co	ntribute to	the cause of death?
IS, F.O. BOX es that the death cer igned by the ettendir be detached for use	by Phy	<u>-</u>				-			10	Yes 2□ No	3 □ Prot	bably 4X Unknown
of Vital Records, P.O. Box (Physician: The law requires that the death certificate has been signed by the ettending rate director, page 2 should be deteched for use a	Completed					_			24a. Wes	s en eutopsy ormed?	COI	ere eutopsy findings eileble prior to mpletion of cause deeth?
The The cata h	Con								10	Yas 2 No	1 [Yes 2 No
r Vital Kystelan: The lis certificata hi	Be	25. Wes case refer exeminer?		Hospitel:			0	26. Pleca of De	ath (Check only	one)		
Afte fune	tion: To	1 Yes 2 2 2 27. Menner of Deet 1 Naturel 2 Accident		28a. Date of Inju	ury	ER/Outpatient 28b. Time of Injury	28c. Inju	4LI Nursing	1	how injury occur		#
Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 4 Homicide	6 Could not be determined	e 28e. Plece of In	njury - At hor tc. (Specify)	me, farm, stre	et, fectory, office		28f. Location City or To	(Street and Numb wn, State)	ber or Rura	l Route Number,
the Hospital hin 24 hours in the Funeral npletely filled	edical	29a. Certifier (Check only one)	1⊠ Certifying Ph 2□ Medicai Exan	nysician: To the best niner: On the basis of end manner si	of examineting	riedge, deeth on end/or inve	occurred et the ti estigetion, in my	ime, dete end plec opinion, deeth occ	e, end due to the urred at the time	ceuse(s) and mo dete end plece,	enner es si and due to	eted. the cause(s)
To th To th	M	29b. Signature end	title of certifier	11	1		29c. Licen	se number		29d. Deta signe	d (Month,	Dey, Year)
		All	1 pl	-CD	to a	1	10	05462	20	July	12,	1999
<u>)</u>		30. Name end addr				23e) (Type, P		(
CAO	t 0	31. Dete filed (Mont			rer's signetu		41,10	3			_	_
Sta Registr	-	JUL 13		Semena	0.	span	(s)					

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99-3934-510 B.K.S	Type or Print in Black Indelible ink.	. Assure All Coples Ar	e Legible.
DEBBRA MOSLEY ITEMS: #23 PART I, 27, PER MEO	State of Maryland / Department of F G773 7-14-99 WR. Certificate of R		33 613611
Physician /Medical Examiner 1. Decedent's Neme (First, Middle, Last) Decedent's Neme (First, Middle, Last) Decedent's Neme (First	Mae Mosley estreet and number)	JULY 8,	Day Yeer 3. Time of Death 0628 AM 4c. County of Death
Funeral 5. Social Security Number 6. S		If Under 24 Hrs. 8. Date of Birth Hours Min. Month, Day, Ya	9/Birthplece (State or Foreign Nountry) 1953 Mary And
10a. State 10b. County Mary and 10b. County Mary and 10b. County Mary and 10b. County 10a. State and Number 2230 Rus 11. Marital Status	A Baltimore Richards Control Research R	re 217	10d. fnside City Limits 1
1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ⋈ No If Yes, Give Yeer or Dates: 13. Was Decedent of H If Yes, specify Cubs 1 □ Yes 2 ⋈ No	lispanic Origin? (Specify Yes or No- an, Mexican, Puerto Rican, etc.) Specify:	14. Race - American Indian, Bleck, White, etc. Specify: Black
Specify only highest gra		ance Worker f	Private Industry
photographic property of the photographic pro	Type, Print (September) 19b. Meiling Address (Street	and Number or Rural Route Number, Ci	Speaks
20a. Method of Disposition 1 Burial 2 Cremetion 3 C 4 Donation 5 Other (Specify	garrison for	ce) 7/16/99 60 est 7/16/99 60	Location - City or Town, Stele Wings Mills, Mo
ASIDA	JOSE Ph. A Dilications that caused the deeth. Do not enter the mode of dying one cause on each line.	L. Russ Funer	al Home o. Md. 21216 Approximate Interval Between
Physician /Medical Immediate Ceuse (Final disease or condition resulting in deeth)	a. ACQUIRED IMMUNUE DEFICIENCY SYN	DROME (AIDS)	Onset and Deeth
P P S P S P S P S P S P S P S P S P S P	Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initialed events	Due to (or as a consequence of):		
cause. Enter Underlying cause. Cloiseses or injury that initieled events resulting in death) Last	Due to (or es e consequence of):		
Pert II. Other significant conditions of	ontributing to death but not resulting in the underlying cause giv		cco use contribute to the cause of death'
The law requires the law requires the law requires the law requires the law requires the law requires the law requires the law requires the law requires the law requires the law requires the law requires the law requirement.		24a. Was an a partormed Linguis	available prior to completion of cause of death?
25. Was case referred to medical examiner?		26. Place of Deeth (Check only one)	2 No 12 Yes 2 No
25. Was case referred to medical examiner? 27. Weaper of Death 28. Weaper of Death 29. Weaper of Death 20. Weaper of Death	Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Oth 28a. Dete of fnjury (Month, Day Year) 26b. Time of Injury Wor	4 U Nursing Home A A Hesidence	

To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Attar th complately filled in by the funaral Medical Certification: Division

5 Pending Investigation 1X Netural

2 Accident 6 Could not be determined 3 Suicide 4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify)

28c. fnjury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 29b. Signeture and wife of certifier 29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year) JULY 8, 1999

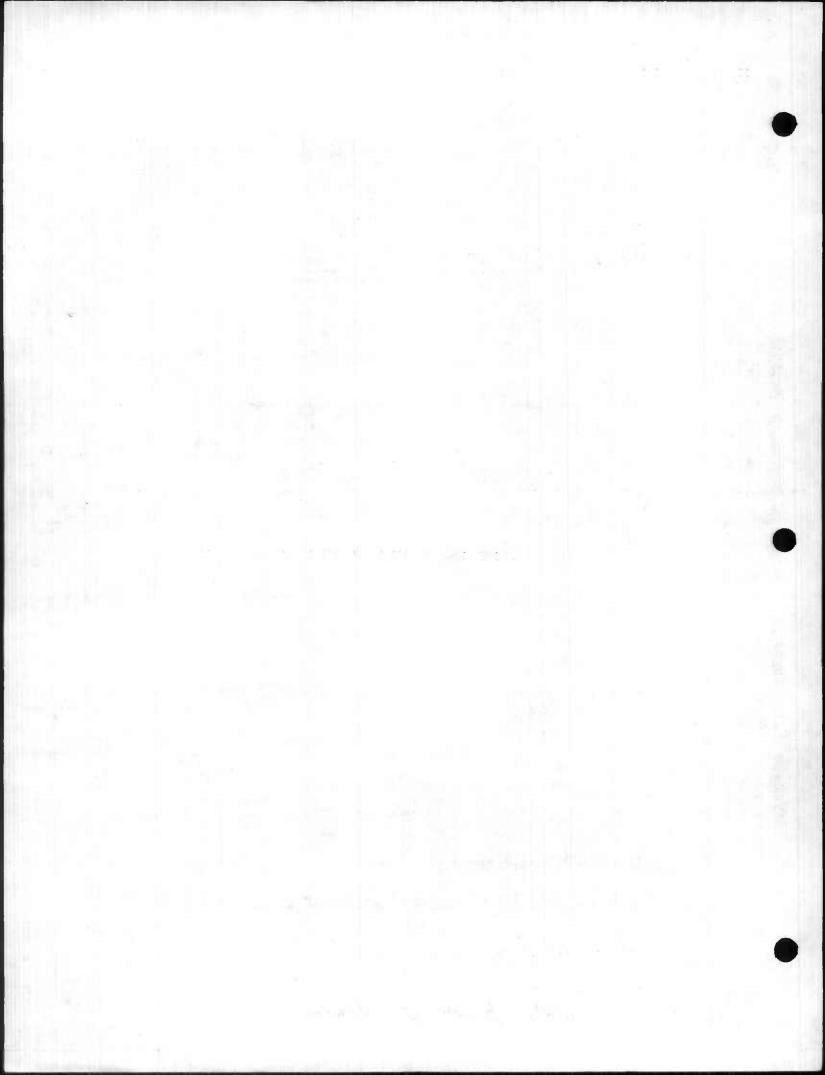
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year)

JUL 13 1999 32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene

				Cer	tificate of	Death		leg. No.	2 5	. 1061	
п	Physician	Decedent's Name (First, Middle, Las	1)				2. Dete of Dea Month	Day	Year	3. Time of Deeth	
Ε,	/Medical	MELVIN				IZER	JULY		1999	14:40 PM	
	Examiner	4e Facility Name (If not institution, give				4b. City, Town, or L		4c. County	of Death		
_		THE JOHNS HOPKI		from triature 1	If Under 1 Yeer	BALTIMORE If Under 24 Hrs.			0.000		
ı	Funeral Director	470 07-0107	7. Age (In yrs. 83	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Aug. 5,		9. Birthple Count	ace (State or Foreign try)	
	D	Usual Residence of Decedent 10a. State 10b. County	10c Cit	ty. Town or Lo	cation				110	Od. Inside City Limits	
	with the Maryland as or 28e-f show Libe notified at			hnsto						1√D Yes 2 No	
	or 28e-f a	10e. Street and Number	30	Jiilis C O	10f. Zip Code		1	I Og. Citizen of \	What Count	IN?	
	ther death, with I fleers 23s or I fleer must be in furners! Dir				15902		4.6	U.S.		,,,	
	for death of flows 23 sines must	824 Bruce Stre	12. Wes Decedent Ever In U	.S. 13. V	1	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		e - America	an Indian,	
020	hours after ural, or itse al Examines od by Fur		Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes:		Yes, specify Cub		Rican, etc.)		White, e		
Maryland 21215-0020	ed within 72-ho yglenn. ver than *natur t, the Medical.	15. Decedent's Edi (Specify only highest grad	de completed)	(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of work	cing	16b. Kind of B	usiness/Ind	ustry	
212	S with	Elementery/Secondary (0-12) Seventh	College (1-4or 5+)	Stool	worker			Stee1			
P	EITES 0			Steet	MOTKET	18. Mother's Nam			ne)		
a a	Mental Me	Joseph Minzer				Till	ie Sch	ompert			
ar)	on and a	19a. Intormant's Neme/Relationship (T	ype, Print)	19b. Mallin	g Address (Street	and Number or Rui	ral Route Numbe	r, City or Town,	State, Zip	Code)	
	and and a saith	Geisel Funeral	Home	734 B	edford	Street,	Johns	town,	Pa.	15902	
ore	- I I I	20a. Method of Disposition 1 ☐ Buriel 2 ☑ Cremetion 3 ☒ I		Plece of Disposemetery, crem	sition (Name of natory or other ple	ce)	Date	20c. Location -	City or Tov	vn, State	
Ē	Pages ment of ant: If Ib ury or o	4 □ Donetion 5 □ Other (Specify,	Co	untrys	side Cr	ematory	7/15/99	Davidsvil	le. Per	nnsylvania	
Baltimore,	Depart Depart Import any in	21. Signature of Funeral Service Licens	Zanen	26:	Name end Address S.Conkli	ng Street,	seph N. Baltimore,	Zannino	Jr. d 2122	Funeral HM	
	Physician	23a. Pert1. Enter the disease, or composhock, or heart failure. List only of	lications that caused the deet ne cause on each line.	h. Do not ente	er the mode of dyli	ng, such as cardiac	or respiratory arr	rest,		Approximate Interval Between Onset and Death	
1	/Medical	Immediete Cause (Final disease or condition	RESPIRATORY	V EATTI	IDE				i	HOURS	
	Examiner	resulting in deeth)	a	or as a conseq						HOURS	
Ц.	je je		HYPOXIA		adi. 100 dij.				1	HOURS	
	executed in and instransit	Sequentially list conditions,	b. Due to (o	or es a consequ	uence ot):					HOURD	
30,	o exe	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	SEPSIS						1	2 WEEKS	
c 68760,	ntificate be executed ing physician and a set the bunal-transit	resuiting in death) Last	PANCREATIC	CANCER						1 YEAR	
Вох	thendin or use		d								
P.O.	requires that the death centines is signed by the attending hould be detached for use eted by Physician/M	Part II. Other aignificant conditions co	ntributing to death but not res	ulting In the ur	ndertying cause gi	ven in Part I.	23b. Did to	X		the cause of death?	
	signe d be d								045 147	va autono din di	
COL	has been signed 2 should be mpleted b						24a. Wes a perfor		ava	ore autopsy findings illable prior to inpletion of cause death?	
of Vital Records,	F # 8 0						1 🗆 Y	es 20No		Yes 2□ No	
/ita	slan: octor	25. Was case reterred to medical examiner?				26. Place of Deel	th (Check only or	ne)			
5		1 ☐ Yes 2 No	1	ER/Outpatien		4 □ Nursing Ho	ome 5 Resid)	
ion	after death. Director: After to in by the funeral ertification:	27. Manner ot Death 1 Netural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day Year)	28b. Time of Injury	M 1 □	ry at rk? Yes 2 □ No	28d. Describe h	ow injury occur	red		
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, ferm, stre	eet, tectory, office		281. Location (S City or Tow	treet and Numb n, State)	er or Rural	Route Number,	
	To the Hospital within 24 hours of To the Funeral I completely filled		sician: To the best of my kno- ner: On the basis of examine and menner steted.								
	within 2 To the comple	29b. Signature and title of dentifier	` 0 0 5	1	29c. Licens	se number	_ 2	29d. Date signe	d (Month, L	Jay, Year)	
		rafell	1 Cantry	L. MI) RE	-S OC	\mathcal{O}	JUL	1 0	1 1999	
		RAPAEL J. CON	completed cause of deeth (item SONJI, M.D.			S HOSPITA	T DATES	MODE :	(T)	01607	
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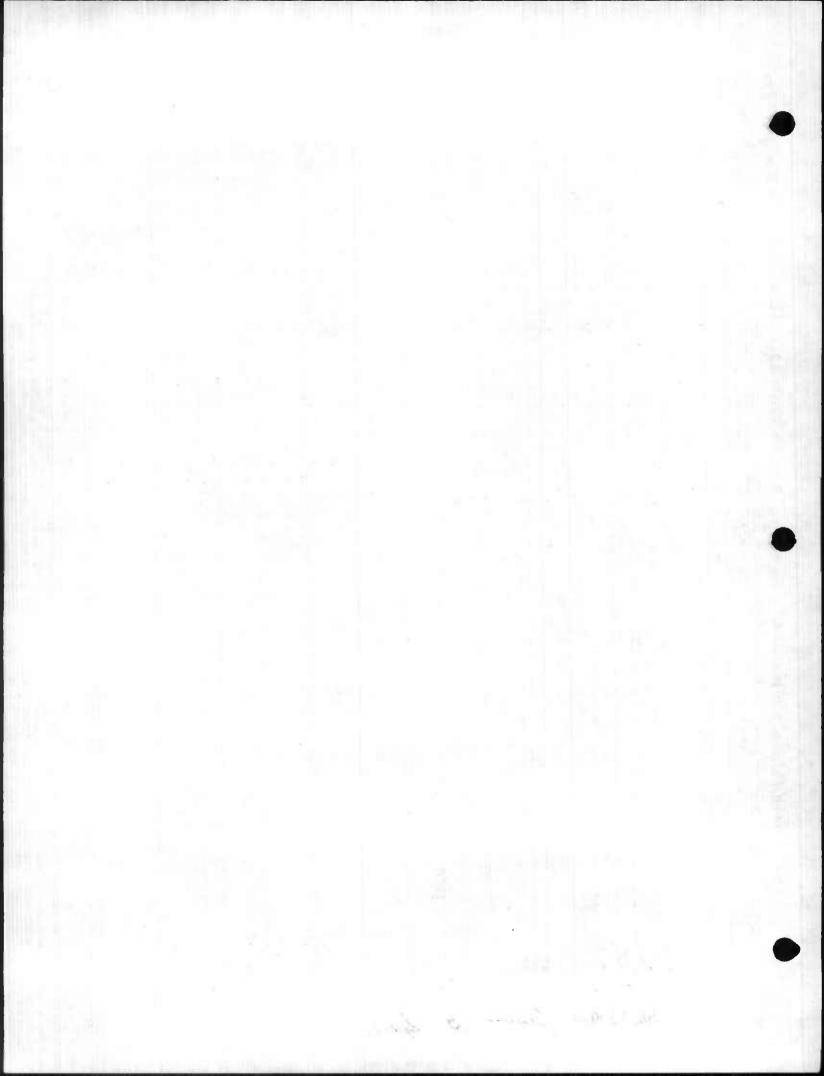
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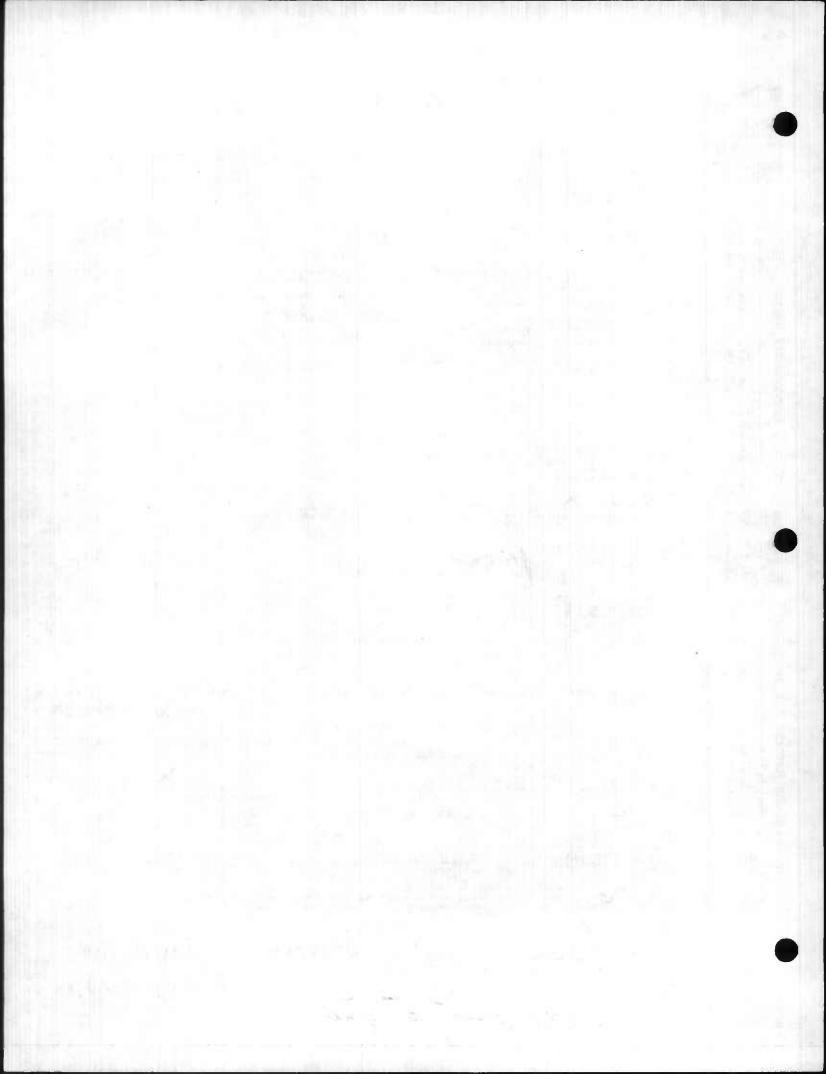


State of Maryland / Department of Health and Mental Hygiene Certificate of Death cedent'a Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month July MARLOURE **Physician** MARTIN 1595 3 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Ellicott City Howard 9966 Oaklea Court If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country)
 New York **Funeral** Days Months Hours 11XM 2□ F 83 055-09-7350 31, 1915 Director July **Usual Residence of Decedent** the Meryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD Howard Ellicott City 1 ☐ Yas 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 U.S.A. 9966 Oaklea Court death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. permit. Peges 1 and 2 should be filled within 72 hours effer of Department of Health and Mental Hygiens. Important: If them 27 is marked other than "instrusit, or them any Injury or other treumstic event, the permitting of the p 1 XYas 2 No If Yas, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: white Á 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) flooring salesman 12 17. Father's Name (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Surname) Pauline Lipsky Ansbacher Jacob 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Flecker daughter 10473 Owen Brown Rd., Columbia, Md. 21044 Penny 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata Baltimore/Washington Crem. 7/14/99 Laurel, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nama end Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road, Columbia, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one cause on each line. Approximete Interval Batween Onset and Death **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical Examine Due to (or as a consequence of): Examiner physician and the buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 790 3 Probably 4 Unknown page 2 should be det Records, á 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? certificate 1 Yas 1 ☐ Yas 2 ☐ No 25. Was case referred to medical examiner? 86 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 NO Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Deviatural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical To the Hosp within 24 hor To the Fune completely fi (Check only onel 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of pe erson who completed causa of death (Item 23a) (Type, Print) Dienen 1105 Exculsion PIC - ITTEC 31. Date filed (Month, Day, Year) 32-Registrar's Signatur State

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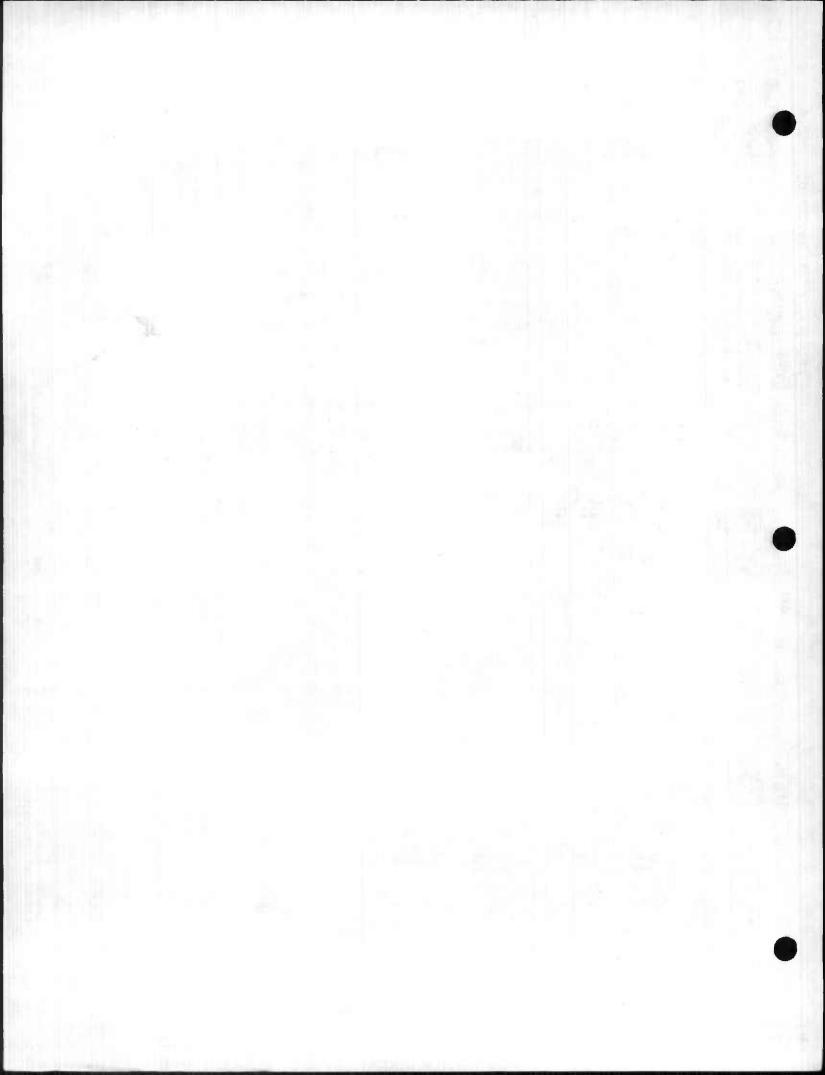


State of Maryland / Department of Health and Mental Hygiene Certificate of Death

21923

Physician	Decedent's Name (First, Middle, Last TEXT YALL	st)	264 0000				2. Date of De Month	eath Day	Year	3. Time of Death
/Medical	EVELYN		MATT	HEWS		Ab City Town	07	11	1999	5:44PN
Examiner	4a Facility Neme (If not Institution, give	street and number)				4b. City, Town, or RANDALLS				
	NORTHWEST HOSPITA 5. Social Security Number 6. S		e (In yrs. last bii	irthday)	f Under 1 Year				IMORI	
Funeral Director	219-26-8319			Yrs.	fonths Days			1937	ALABA	elace (Stete or Foreign etry) AMA
ms 23s or 28s-f show Lithail be notified at heral Director	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	vn or Locat	ion				1	0d. Inside City Limits
ret for	MD BALTIM	IORE	PTK	ESVIL	J.E					XX Yes 2 No
or 28e-f s be notified Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
al D	806 SMOKE TREE RO	AD			213	208		US.	A	
thems 23s or 28s-f show siner must be notified at Funeral Director	11. Marital Status	12. Was Decedent E Armed Forceş?		13. Was	s Decedent of I	Hispanic Origin? (S pan, Mexican, Puer	Specify Yes or No to Rican, etc.)	0- 14. Raci Blac	e - Americ	en indian, etc.
Exam by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ AN If Yes, Give Year or Dates:	lo	10	Yes 2 No	Specify:		Specify	: BI	LACK
ygiene. wer than "natur It, the Medical. Completed	15. Decedent's Ed (Specify only highest gra	ucation de co <i>mpleted)</i>	16a	(Give kin	t's Usual Occu d of work done	during most of wo	rking	16b. Kind of Bu	siness/Ind	dustry
the Man	Elementary/Secondary (0-12)	College (1-4or 5 I YEAR	+)		NOT use retire	*		HOME		
d other event, I Be Cc	17. Father's Name (First, Middle, Last)				ODZNIII		me (First, Middle	, Maiden Sumam	10)	
marked or marked or To B	ELLIS	GANDY				ROS	Δ	т	ASTE	
and a man	19a. Informent's Neme/Relationship (1	ype, Print)	190	b. Meiling A	Address (Stree	t end Number or R				
27 th	ELROY MATTHEWS, S	R. /HUSBAN		80	6 SMOKE	E ROAD, P				
if harr	20a. Method of Disposition 12 Burial 2 Cremation 3	Removal from State		ry, cremate	ory or other pla		Date	20c. Location -		own, State
Department mportant: I any injury o	4 Donation 5 Other (Specify	-	DKU.		DGE CEM		//1//99	BALTO.,	MD.	
Depa Impo any i	21 Signature of Funeral Service Licen	Mi		J		MORTON				
	23s Party Enter the disease or com-	dications that caused	the death Do	1	701 LAU	RENS STR	EET, BAI	TO, MD.	212	17 Approximate
nysician	23. Part . Enter the disease, or company to the com	one cause on each lin	10.	not enter t	ne mode or dy	ing, such as cardia	c or respiratory e	arrest,	1	Interval Between Onset and Death
Medical	tmmediete Cause (Finel disease or condition	Spi	DSIS						İ	10days
aminer	resulting in death)	a	Due to (or as e	consequer	nce of):			-	1	rogays
in er		h								
tending physician and ruse as the burlal-transit an/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury		Due to (or as a	consequer	nce of):					
physician as the buni edical E	Cause. Enter Underlying Cause (Diseese or Injury that initiated events	C	Due to (or as a	000000000	an of):			<u> </u>	1	
as th	resulting in death) Last	,	Jue to (or as a t	consequer	ice ory.					
or use a		d							1	
d by the atte	Part II. Other algnificant conditions co	entributing to death bu	it not resulting i	in the unde	rlying cause gi	ven in Part i.	23b. Did	tobacco usa cor	ntributa to	the cause of death?
ed by the a deteched y Physic	Asthma						1 🗆	Yaa 2 No	3 Pro	bebly 4 Unknown
2 2 2							24a Was	s an autopsy	24b. W	ere autopsy findings
page 2 should I							perf	ormed?	av co	ailable prior to impletion of cause death?
ate has been signed by the page 2 should be deteched Completed by Phys							10	Yes 2 No		Yes 2 No
	25. Was cese referred to medical					26. Place of De	ath (Check only		, ,	163 2010
I direct	axaminer?	Hospital:	nt 2 ER/Ou	utpatient	3□ DOA Ot	hor		Idence 6 Oth	er (Specif	(y)
th. After the funeral	27. Menner of Deeth 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injur (Month, Dey	Year) 28b.	Time of tnjury	28c. Inju Wo M 1	ny at ork?]Yes 2 ☐ No	28d. Describe	how injury occurr	red	
is effected. After this certification: To Be	3 Suicide 6 Could not be determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Funer fely fill	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examination an	e, death oc nd/or invest	curred at the ti	ime, dete end place opinion, deeth occ	e, end due to the urred at the time,	cause(s) and ma , dete end plece,	nner as s	tated. o the cause(s)
Med Med	29b. Signature and title of certifier	and mainer sta	ww.		29c. Licen	se number		29d. Date signed	d (Month,	Day, Year)
>= 0	Dard /	South	M	11	D-	841-	2	Tul 11	19	99
	30. Name and address of person who o	completed ceuse of de	eath (Item 23a)	(Type, Prir	nt)	_070	_	July	1 1	1 1
	J. Boston	North	west	Hos	11	Cente	r 54	01 Old	Co	art Road
State	31. Date filed (Month, Dey, Year)	32. Registra	r's Signature	4	1					

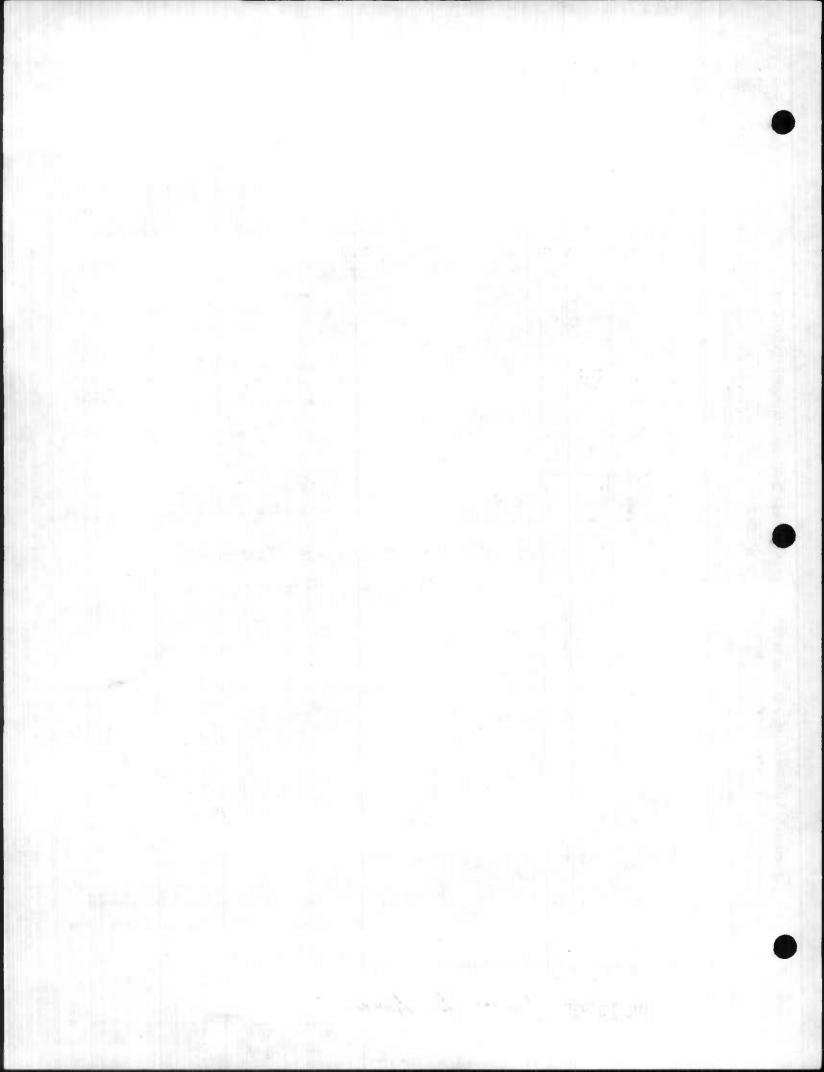
DHMH 16 Ray 6/95



AMEND: #10F,		ment of Health and licate of Death	Reg. No.	99 21924
Physician	1. Decedent's Neme (First, Middle, Last) Anna Muszynski		2. Dete of Death Month Day	3. Time of Death
/Medical Examiner	al	4b. City, Town, or	07-07-99 Location of Death 4c. 0	7:20 AM
Cxammer	709 W. Baker Ave.	Abingdo		Harford
Funeral Director		Under 1 Year If Under 24 Hrs onths Deys Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign Country) MD
pu s	Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location	00		10d. Inside City Limits
with the Maryland a or 28a-f show Le notified at Director				-15 Ves 2 1 No
r 28a-f si	10e. Street and Number	Of. Zip Code	10g. Citize	en of What Country?
23a or	709 W. Baker Avenue	21009	USA	
o20 urs after dea alt, or flems by Funer	3 ☐ Widowed 4 ☐ Divorced Year or Detes:	Decedent of Hispanic Origin? (Ss. specify Cuban, Mexican, Puerl		4. Race - American Indian, Bleck, White, etc. Specify: WHITE
1 21215-0 led within 72 ho tygiene. The Heater It, the Heater Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Homemal	s Usuel Occupation of work done during most of wor VOT use retired)	rking 16b. Kind	d of Business/Industry
be filed y tal Hygie d other permit be Co	17. Father's Name (First, Middle, Last)		me (First, Middle, Maiden S	
irylanc should be fi ad Mental H marked off martic ever	17. Father's Name (First, Middle, Last) BIELING SR. Frank Beling, Jr.		Jnknown DOB	
A 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Ar	ddress (Street end Number or Ru Baker Ave.,		
or other	20e. Method of Disposition 20e. Method of Disposition 1 Buriel 2 Cremation 3 Removal from State 4 Donatton 5 Other (Specify) St. Stanis	n (Name of ry or other place)	Dete 20c. Loc	ation · City or Town, State
Baltim permit. Per Department important: any injury	21. Signeture of Funerel Service Licensee Kac	me end Address of Facility. CZOTOWSKI F. 01 Dundalk Av	н.	
Physician /Medical Examiner	23a. Part 1. Enter the disease, or combicetions that caused the death. Do not enter the shock, or heart feilure. List only one cause on each line. Immediate Cause (Finet disease or condition resulting in death) Due to (or as a consequence)	e mode of dying, such as cardied	•	Approximate Interval Between Onset end Death
Geath certificate be executed death certificate be executed a strending physician end and for use as the bunal-transit iclan/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or es e consequence of the cause of the cause) c. Due to (or as a consequence of the cause)	ce of):	zhermer	Disense
. Be atte	Pert It. Other algnificant conditions contributing to death but not resulting in the under	tving cause given in Pert I	23b. Did tobacco u	se contribute to the cause of death?
is, P.O. Box 6 ss that the death certification by the attending it be detached for use as by Physician/Me	Hudry Hypotymond Dr.	yang dadda giran ari ari		No 3 Probably 4 Unknown
Cord requir should leted		107	24a. Wes an autops performed?	24b. Were autopsy findings available prior to completion of cause of death?
The interpretation	E		1 □ Yes 2 🔀	(No 1 □ Yes 2 □ No
f Vital Revenue secreticate has director, page 2	25. Wes case referred to medical examiner?		eth (Check only one)	
- 2 00			tome 5 Aesidence 8	
Division or Attending ther death. Director: After in by the fune entification	27. Manner of Death 1 Diverter 5 Pending investigation 2 Accident 3 Suicide 4 Homicide 4 Homicide 4 See Place of Injury - At home, ferm, atreet, building, etc. (Specify)	28c. Injury et Work? 1 Yes 2 No factory, office	28d. Describe how injury 28f. Location (Street and City or Town, State)	Number or Rural Route Number,
ne Hospital n 24 hours ne Funeral pletely filled		curred et the time, date and place getion, in my opinion, deeth occu	e, and due to the cause(s) a urred et the time, date end p	and manner as stated. plece, end due to the cause(s)
within To the comple		29c. License number	29d. Date	signed (Month, Day, Year)
->-0	Barre 12 Talada -0	D20807	71	12/99
	30. Name end address of person who completed cause of death (Item 23a) (Type, Print		mp -	7-(2.0)
State	21 Date filed (Meeth Day Vere)	100300		0.00.7
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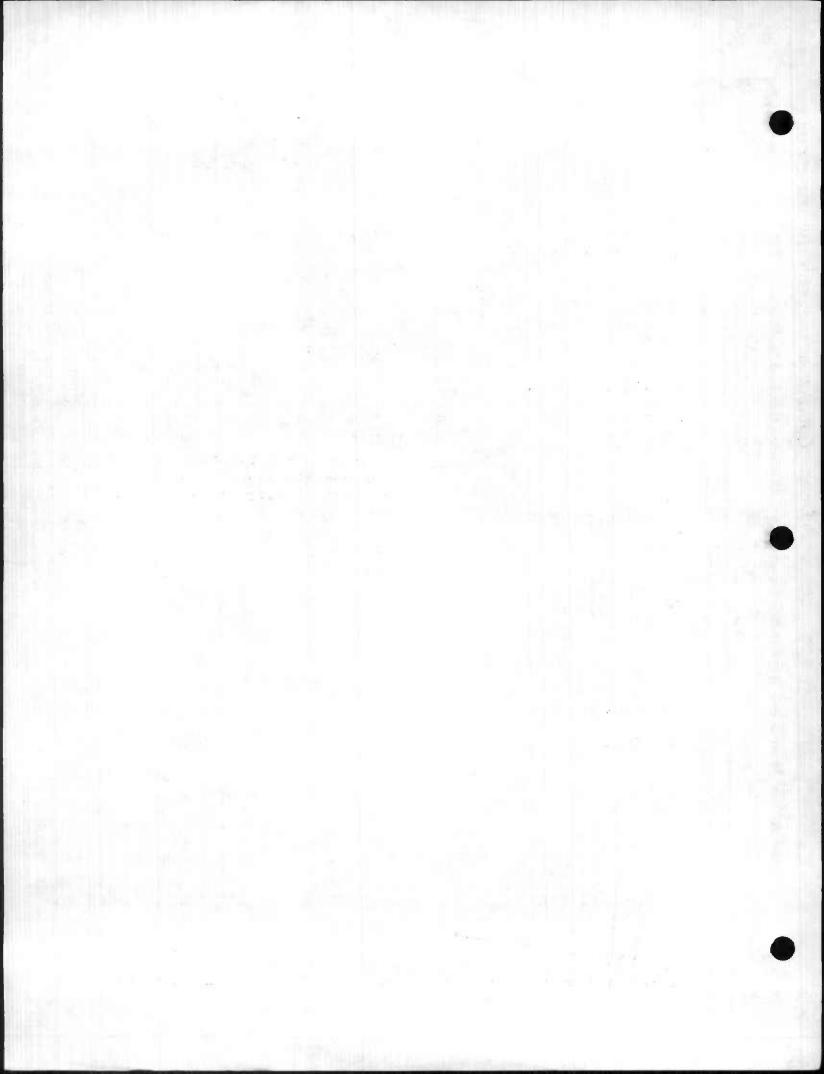
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Registrar

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				State of M	Maryland		rtment of F tificate of		d Mental Hy	rgiene 5 Reg. No.	5	21920
			1. Decedant's Name (First, Middle	ı, Last)					2. Data of D		Vene	3. Tima of Death
	Physici /Medi		IRENE LYDIA M	ASEK					Month JULY	Dey 10, 19	Yaar	5:30 A.M
	Examir		4a. Facility Nama (If not institution		r)			4b. City, Town,	or Location of Deal			3.30_A.M
	Funeral Director		GENESIS ELDER 5. Social Sacurity Number 217–07–0135		RAVEN Aga (In yrs. lasi 93	t birthday) Yrs.	If Undar 1 Year Months Days	TOW:		BAI ay, Year)	TIMC 9. Birthr Cour MARY	RE blace (Stata or Foraign ntry) LAND
	pue *		Usual Rasidance of Decedant 10e. Stete 10b. County		10c. City, T	fown or Loc	eation					Od. Inside City Limits
	the Marylen r 28a-f ehow	5		TIMORE		OWSON	Allon				,	1 ☐ Yas 2 ☒ No
	the M 28a-f	Director	10e. Street and Number	LIFORE	10	DWSON	404 75 Ondo			10g. Citizen of	45	••
	÷ 0 %		1615 MUSSULA RO	DAD			10f. Zip Code 2128	36		USA		itry?
	after death w	Funeral	11. Maritel Status	12. Was Decedan Armed Forces	t Evar in U,S.	13. V	Ves Decedant of H Yas, specify Cube	lispenic Orlgin? en, Maxican, Pu	(Specify Yas or Nearto Rican, atc.)	o- 14. Rad Biad	e - Americk, White,	can fndian, atc.
Maryland 21215-0020	should be filed within 72 hours after end Mental Hygiena. Is marked other then "naturelt, or the aumatic event, the Magical Examina	by Fu	1 ☐ Navar Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 Tas 2 ff Yes, Giva Yaar or Datas			□Yas 2☐xNo			Specify	<i>y</i> :	ITE
9-0	"naturel",	ted	15. Decedent	's Education	1		ant's Usual Occup			16b. Kind of B		
21	within 7 ena. than "n	Completed	(Spacify only highes Elamantary/Secondary (0-12)	Collaga (1-4or	5+)	lifa. E	kind of work dona OO NOT usa ratired	dunng most of d)	working			
21	d withi glena. or than	No.	6TH GRADE			SEW	ING_OPERA	ATOR		UPHOI	STER	Y
pu	be filed that Hyg d other event,	Be (17. Fathar's Nama (First, Middla, I	Last)					Nama (First, Middle			
Va	should be filed nd Mental Hygi merked other metic event, I	To	HARRY GEORGE	BAIRD	_			HEST	ER VIOLA	BRAZIER		
a	d 2 should th end Men 7 Is marka traumatic		19e. Informant's Name/Reletions	nlp (Type, Print)		19b. Mailin	g Address (Street	and Number of	Rural Route Numb	er, City or Town,	State, Zip	Code)
	permit. Pages 1 and 2 s Department of Health er Important: If Itam 27 is any injury or other trau 900.8.		DOROTHY HEFNER	R DAU	GHTER	1615	MUSSULA	A ROAD	TOWSON,	MD 2128	36	
Baltimore,	of Herr Nerr		20a. Mathod of Disposition		cem	a of Dispos	sition (Nama of etory or other place	ce)	Data	20c. Location	City or To	own, Stata
Ĕ	Pages nent of i int: If its		1 Surial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other (Sp			CIVIONI	CEMETERY	7	7/12/99	BALTI	MODE	MD
alti	permit. Departmine Importa		21. Signature of Funaral Sarvica I	icensaa	FAIL		Nama and Addra		1/12/95	DALITI	IORE:	.FID
m	SOE SO		I Malon	11/4	/	TH	HE JOHNSO	ON FUNE	RAL HOME,	P.A.		
	_	5	23e. Pert1. Entar tha disaesa, or	complications that cause	ad tha daath. I	Do not anta	521 LOCH ir the mode of dvir	RAVEN I	BLVD. TO	WSON, MI	21	286 Approximata
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	/Medical		Immediate Causa (Finel	6.	~					1	- 11	
	Examiner		disaasa or condition resulting in deeth)	* de	100	2						3-4
		ē		•	Due to (or as	s a consequ	uence of)				i	3-4 WKS
	pet Insit	듄		p b De	my	di	alle	7			i	00/05
	be axecuted lotan and burial-transit	Examiner	Sequentially list conditions, if any, laeding to immediate causa. Entar Underlying Cause (Diseasa or Injury		Due to of es	s a consequ	uence of):					
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89	ifficata g phys as the	8	rasulting in daath) Lest	1	Due to (or as	s a consaqu	ianca or):				1	
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Ö	v require been sij should b	Completed							perf	ormed?	ev	ailable prior to empletion of cause
3ec	has t	idπ										daath?
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5	Physic this c	2	1 Yas 2 No	Hospital: 1 Inpat		/Outpatient		4 Nursin	g Homa 5□ Ras	Idanca 6 □Oth	ar (Specii	y)
Division of	ofing P. Aftar t funera	Certification:	27. Manner of Deeth 1. □ Natural 5 □ Pending	28e. Dete of fn (Month, D	ury 28 a <i>y Year)</i>	Bb. Tima of Injury	28c. Injur Wor		28d. Describe	how Injury occur	red	
Sio	Attending in death.	cati	2 Accidant invastig				M 1 🗆	Yas 2 □ No				
Z	her d frect n by	E	4 Homicide detarmi	ned 208. Place of It	njury - At home atc. <i>(Specify)</i>	e, ferm, stre	et, fectory, office		28f. Location City or To	(Streat and Numl wn, Stata)	er or Run	al Route Number,
0	ital or rat D	S										
	To the Hospital or Attano within 24 hours after deatl To the Funeral Director: completaly filled in by the	edicai	(Uneck only 2) Medical E	Physician: To the besi examiner: On the basis	t of my knowled of axamination	dga, daath and/or inv	occurred at tha tin	na, date and ple pinion, deeth o	aca, and dua to the ccurred at the time	causa(s) end me date and piece,	enner as s	tated. o tha causa(s)
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			30. Nama and address of person v	who complated cause of	death (Item 23	Ba) (Type, F	rint) 360	1 20	eh Ro	every	Bl	vd.
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State of Maryland / Department of Health and Mental H

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Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or hams 23s or 28s-1 show eny injury or other traumatic event, the Medical Examinat must be notified at	The second secon

	1. Decedent's Name	e (First, Middle, L	ast)				f Death		2. Date of De	Reg. No	,		3. Time	of Death
ian	Mark		Anth	ony	Ne	a1			JULY (05, Day	1999	Year	10:	01 AM
cal ner	4a Facility Name (II	f not institution, g	ive street and n	umber)			4b. City, To	own, or Lo	ocation of Deat	-	. County	of Death		
	2706 L	EWIS AVE					5	SUITI	AND	F	rinc	e Geo	orges	
П	5. Social Security N 418-94-5	CORRECT CO.	Sex XXXM 2□ F	7. Age (In 34	yrs. last birthday) Yrs.	Months Day		r 24 Hrs. Min.	8. Date of Bir (Month, Da Dec. 2			9. Birthple Count	ace (State	or Foreign
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al Director	10e. Street and Nun 1118 Del:					10f. Zip Code		303		10g. Cit	tizen of W	hat Count	iry?	
by Funeral	11. Marital Status 1 (∑Never Marria 3 □ Widowed	ed 2 Married	12. Was De Armed F 1 Yes if Yes, G Year or	orces? 200No ive		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2000 No	ban, Mexica	in, Puerto	ecify Yes or No Rican, etc.)	0-		- America k, White, e		
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npie	Elementary/Secon			(1-4or 5+)	life.	DO NOT use reti	ed)	o, or work						
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9	17. Father's Name (st)				18. Moth	_	e (First, Middle					
)	Wylie (C. Neal						Rosa	nna	s.	Ada	ire		
4 Donation 5					ng Address (Stre		per or Run	at Route Numb	oer, City o	or Town,	State, Zip	Code)		
	Wylie (C. Neal	/ Fath			8 Dellwo	od	Doth	nan, AL	36	303			
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State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. A. Fowler 111 Penn S

111 Penn Street, Baltimore, Maryland 21201

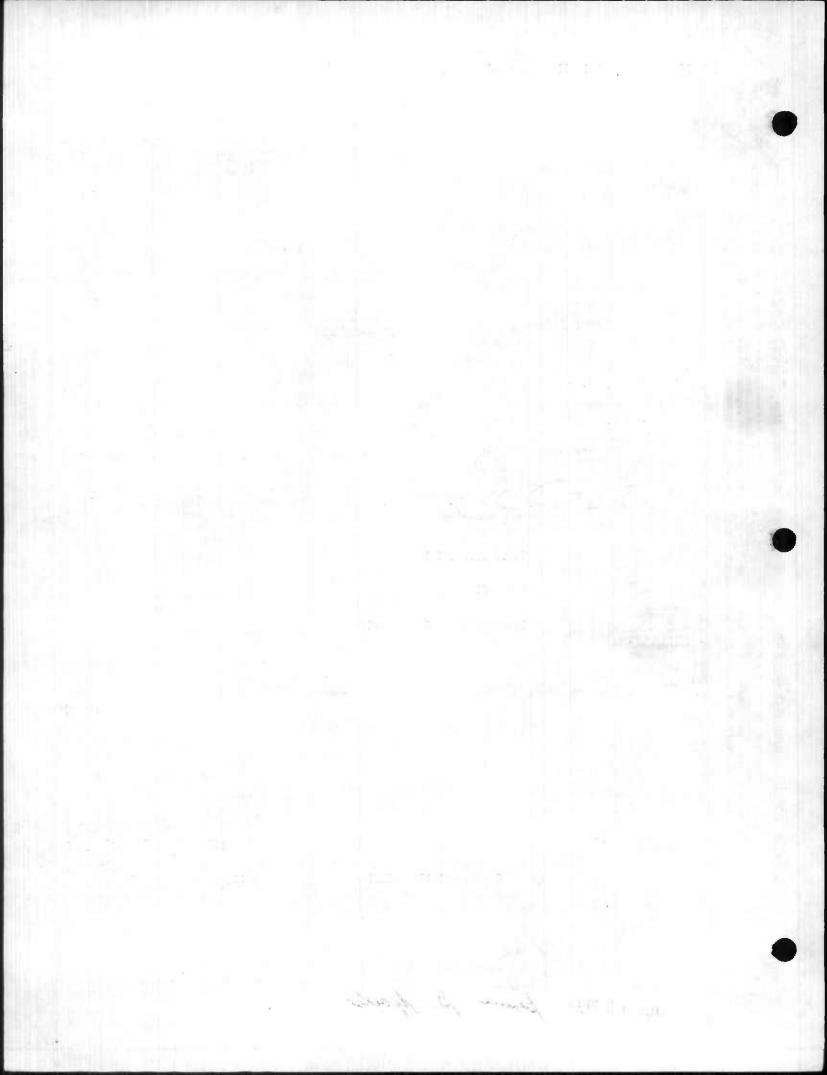
29d. Date signed (Month, Day, Year)

JULY 06, 1999

DHMH 16 Rev 6/95

29c. License number

O.C.M.E.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death eilson Month Robert JU14 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Genesis Eldercare - Cromwell Center Baltimore Baltimore County If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0ct. 29 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foreign 1**X** M 2□ F Pennsylvania 83 Yrs. 705-07-8877 Usual Rasidance of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Baltimore Parkville 10e. Street end Number 10f. Zip Code 10a. Citizen of What Country? 9527 Powderhorn Lane 21234 United States 12. Was Decedenf Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specify: White 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Office Worker Rail Road 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Surname) William E. Neilson, Sr. Maude Schafer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. Neilson, Jr. / Brother 1167 Old County Road Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Steta 1 ☐ Burial 2X Cremetion 3 ☐ Removal from State Hilltop Service Corp. 7/12/99 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not antar tha mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final months disease or condition rasulting in death) as a consequence of): Thicke's Encephalo pathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobecco use contribute to the cause of deeth? emetra 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 26. Placa of Death (Check only ona) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work?

Examiner that the death certificate be executed physician s the buriel Box 68760. Records, P.O. page 2 certificate Division of Vital Hospital or Attending Physician: 24 hours efter deeth. Funeral Director: After this certificately filled in by the funeral director, t

Physician

/Medical

Examiner

Funeral

Director

rel', or items 23s or 28s-f show Examiner must be notified at

naturel', or

permit. Peges 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other than "natur any Injury or other treumatic avent, the Mexican

Physician /Medical

Examiner

filed within 72 hours efter

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

Physician/Medicai Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. þ Completed Be 25. Was case refarred to medical examinar? 1 Yes 2 No Certification: To 27. Mangar of Death 5 Pending investigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the fima, data and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certify

2 Medical Exeminer: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

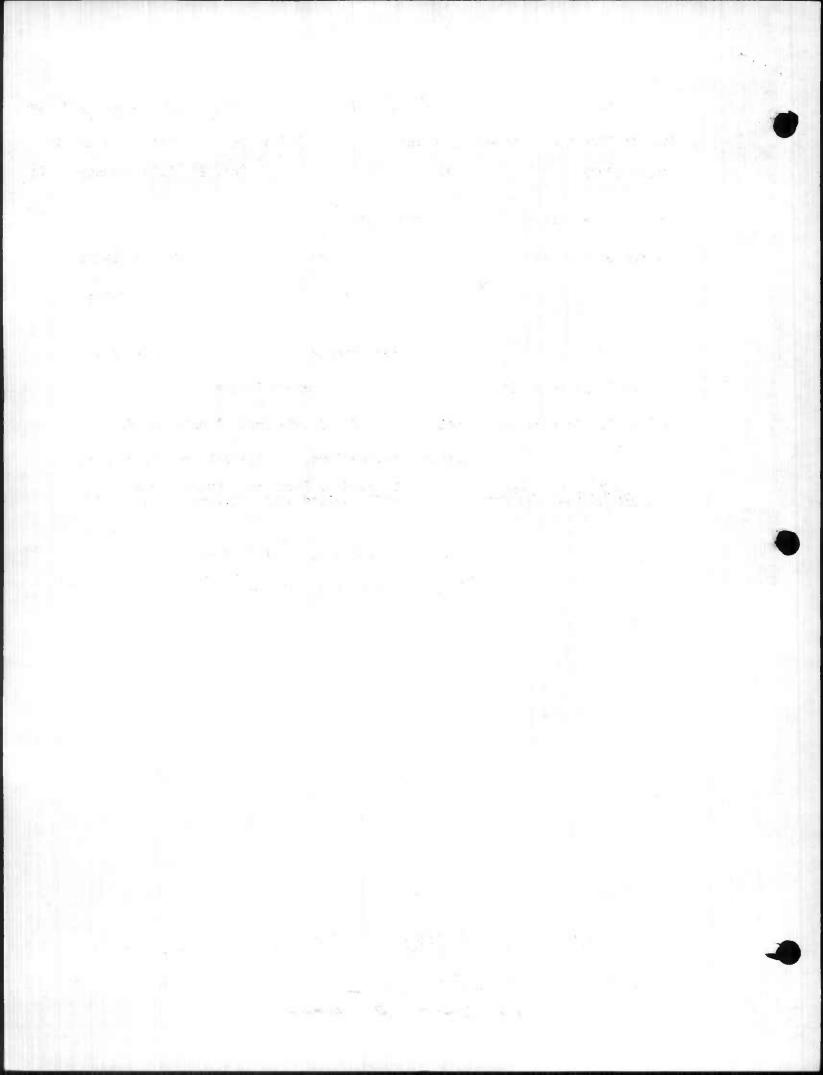
30. Name and addrass of person who complated cause of death (Itam 23a) (Type, Print)

MINGS X 2. HOU Spo) ENOrTher Park Way Baltimore 21214

32. Ragistrary Signature

DHMH 16 Rev 6/95

To the Hospital or within 24 hours eft To the Funeral Di completely filled in



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** NAHRGANG V. DONALD 5: 40 AM July 1999 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Columbia Howard Howard County General Hospital H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 M M 2 ☐ F Birthplace (State or Foreign Country) **Funeral** Days Months Director 83 479-09-3504 December 18, 1915 lowa Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rail, or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director Maryland Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21046 U.S.A. 8580 Guilford Road Funeral 12. Was Decedent Ever in U,S. Armed Forces?
1 12 Yes 2 10 No 11 1941
14 Yes, Give 1941
1961 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after near of Healin and Mental Hygiene.
Intel from 27 is marked other than "natural", or the wirl from 27 is marked other than "natural", or the lay or other thaumatic event, the land of the layour. 1 Never Merried 2 Merried Baltlmore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: 1940 þ 3 ☐ Widowed 4 ☐ Divorced White 1964 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) **Property Management** Maintenance Supervisor 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gladys Crystal Kelly Raymond William Nahrgang 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8580 Guilford Road Columbia, Maryland 21046 Ms. Frances Nahrgang 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Denation 5 Other (Specify) Department of important: If any injury or 07/12/99 Baltimore, Maryland Metro Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 MOOSES Part 1. Enter the disturble, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical endocadat subnente Sacterial Examiner Due to (or as a consequence of): Examiner stroke ician and burial-transit The law requires that the death certificate be executed Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Box 68760, Physician/Medical Due to (or as a consequence of): 980 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 25tho 3 Probably 4 Unknown insufficiency Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Dinkete page 2 s 1 Yas 1 ☐ Yes 2 No of Vital or Attending Physicien: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Suppatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Tima of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation Division 1 Deturel 1 Yes 2 No death. 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 1 StCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated. edical 29e. Cartifier (Check only one) To the F within 2 29b. Signeture and title of certifier 29c. License number 7377 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) CHE PETER Collem sin

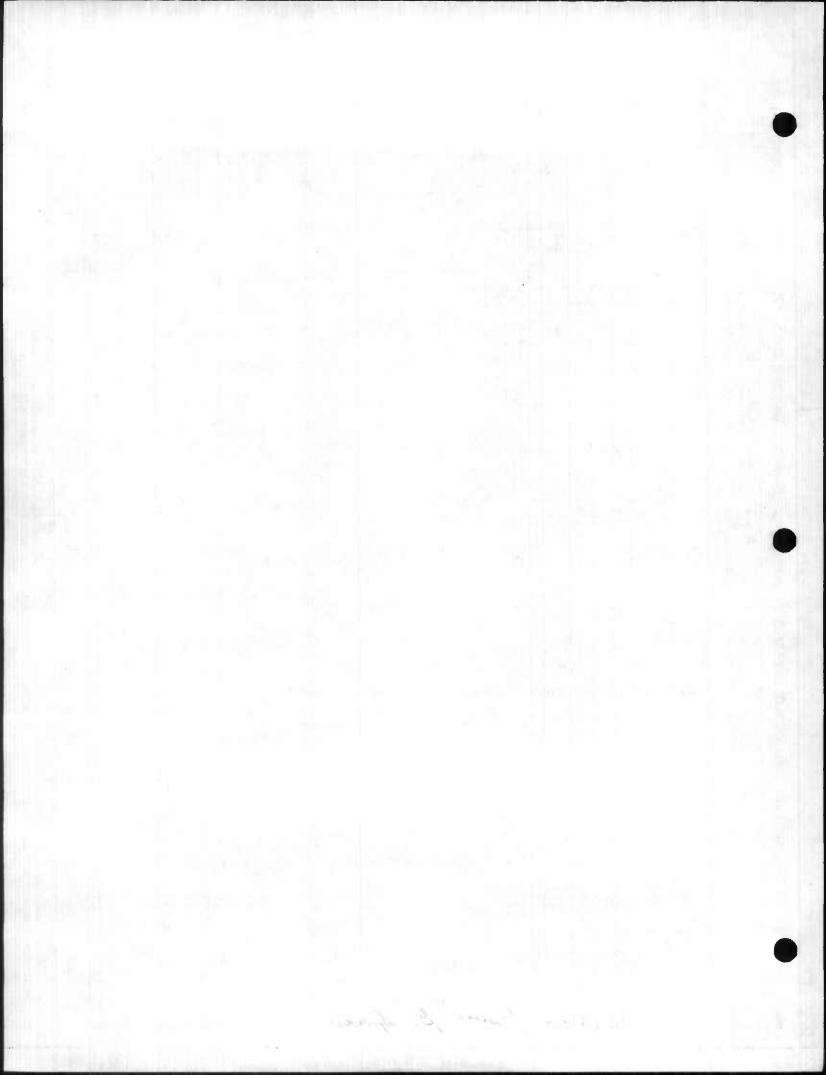
DHMH 16 Rev 6/95

State Registrar

1 3 1999

31. Dete filed (Month, Day, Year)

32. Registrar's Signature



filled within 72 hours after

Hygiens. Wer then

Pages 1 and 2 should be nent of Health and Mental

Baltimore, Maryland 21215-0020

Elementery/Secondery (0-12)

Coilege (1-4or 5+)

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Physician /Medical Examiner	4e Facility Name (E POYNE			Æ			4b. City, To		2. Date of Dea Month JULY ocation of Death	9, 19	Year 99 inty of Death	3:20 AM
Funeral Director	5. Social Security NUNKNOWN Usual Residence of		Sex 1 □ X M 2 □ F	Age (In yrs. I 1. 5	ast birthday, Yrs.	Months	1 Yea		24 Hrs. Min.	8. Date of Birth (Month, Day 06-1.0-	r, Year)	Coun	laca (State or Foreign try) TIMORE
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MIDDLE SCHOOL

Important: If Item 27 any injury or other to **Physician** /Medical

Examiner

sician and burial-transit The law requires that the death certificate be executed physician the buria 88 980 signed by the a page 2 or Attanding Physician: funeral 24 hours after death.

Division of Vital Records, P.O. Box 68760

Completed 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FREDDIE POYNER JOYCE SMITH 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2317 LINDEN AVE, BALTIMORE, MD 21217 JOYCE POYNER, MOTHER 20e. Method of Disposition 20b. Pleca of Disposition (Name of cametery, cremetory or other pleca) 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removei from Stete 4 ☐ Donetion 5 ☐ Other (Specify) KING MEMORIAL PARK 7-9-99 RANDALLSTOWN, MD 22. Name and Address of Facility
HOWELL FUNERAL ineral Service Licensee HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207 Vert1. Enter the disease, or complications that cau and the deeth. Do not enter the mode of dying, auch as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Wound of Char Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequença of): Physician/Medical Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 25KNo 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy performed? y Yes 2□No Yes 2 No Be 25. Was casa referred to medical exeminer? 28. Place of Deeth (Check only one) Hoapitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence KNOther (Specify) AT SCENE edicai Certification: To YoxYes 2 No 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of Injury 28c. Injury at Work? 1 Neturel 5 Pending Shot subject 7-9-99 1 ☐ Yes 2 123 No investigation 317 AM 2 Accident 281. Location (Street and Number or Rural Route Number Sity or Town, Stete) 6 Could not be determined 3 Suicide 28e. Pieca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Chomicide \$200 Park Hought Au Store 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

***Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number butono O.C.M.E JULY 9, 1999 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

STUDENT

State Registrar

filled in by

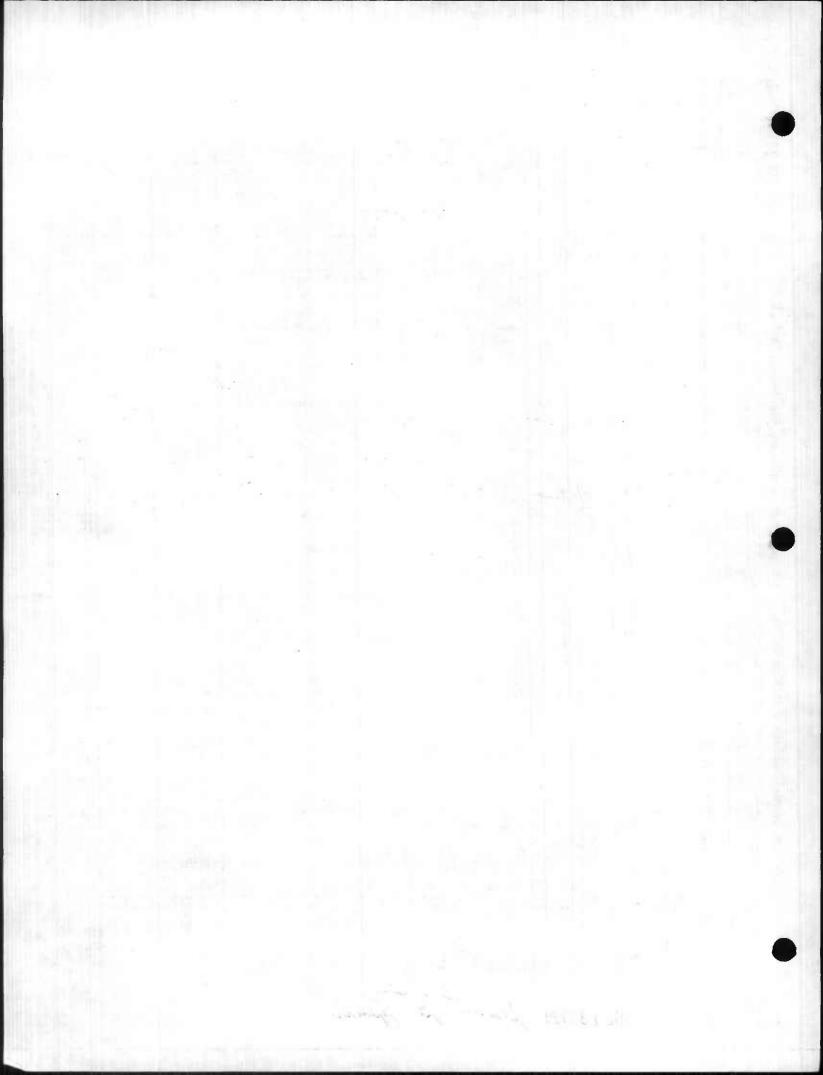
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31. Dete filed (Month, Day, Year) JUL 1 3 1999

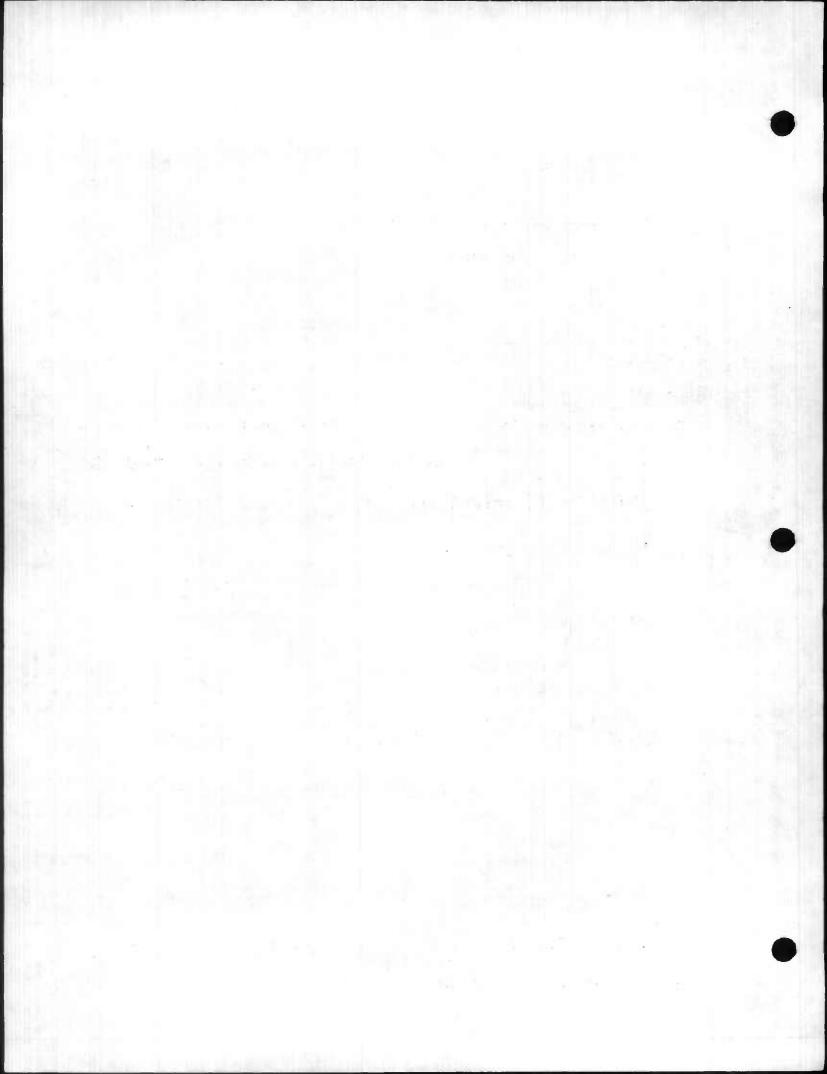
111 Penn Street, Baltimore, Maryland 21201 32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene 99 2 99

			Certificate of	of Death	Re	g. No.	
Physician /Medical	1. Decedent's Nama (First, Middle, Last) ANDREW		PAR	KER	2. Dete of Death Month JULY		Yee 3. Time of Death 3:38 PN
Examiner	4e Facility Neme (If not institution, give street ar			4b. City, Town, or		4c. County o	
<u> </u>	GOUD SAMARITAN			BALTIM	-	BALTIN	
Funeral Director	5. Social Security Number 217-38-5111 Usuel Residence of Decedent	7. Age (In yrs. last b	Yrs. If Under 1 Yr Months Da	aar If Under 24 Hrs. lys Hours Min.	8. Data of Birth (Month, Dey,	Year)	Birthpleca (Stete or Foreign Country) M D
M M	10a. Stata 10b. County	10c. City, Tox	wn or Location				10d. Inside City Limits
the Maryla 28a-f show soliffied at ector	MD Baltimore	Co. Woo	dstock				1 ☐ Yes 2√ No
with the	10e. Street and Number		10f. Zip Cod	de .	10	g. Citizen of Wh	hat Country?
25a c 25a c ant b wit	10016 Village Gree	n Drive	2.	1163		U.S.	Α.
0020 hours after death with the Maryla ural, or Hams 23a or 28a-f sho al Examiner must be notified at d by Furneral Director	1 Never Merried 20 Merried 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Decedent Ever in U,S. ed Forces? Yes 2 No s, Giva or Datas:	13. Wes Decedent If Yes, specify (of Hispanic Origin? (S Cuban, Mexican, Puart No Specify:	pecify Yes or No- o Rican, etc.)	Black, Specify:	- American Indien, , Whita, atc.
21215-0020 ed within 72 hours at yopiens, er than "natural", or s, the Medical Exam Completed by I	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle		a. Decedent's Usual Oc (Give kind of work do life. DO NOT use re	one during most of wor	king	6b. Kind of Bus	
A 3255 0	12th grade 4 yr	s+ A	ccountan		- Wine Adidello A		of Energy
Be Be	17. Father's Neme (First, Middle, Last)				ne (First, Middle, M	laiden Surneme,)
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altimore mit. Pages 1. partment of He portant; if ter y injury or oth	1 X Buriai 2 ☐ Cremetion 3 ☐ Removel	from Stete cemete	ery, cremetory or other	plece)			
altim nit. Pa antmen ortant: injury	4 Defetion 5 Other (Specify)	Garr	22. Neme and A		//14/99	Owing	gs Mills, Mo
Department of the service of the ser	I frome A.	Thompson	March F	/H West	Baltin	ore Mo	21215
) Physician	Entar the disease, or complications or heart feilure. List only one cause	thet caused tha death. Do on each line.	not enter the mode of	dying, such as cardiac	or raspiratory arra	st,	Approximeta Interval Between Onset and Deeth
/ /Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth)	Sep					2 days
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executed and instransit	D		consequence of):	-(10(111)	119/11	ing	1
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68760, fificate be executed g physician and as the burial-transit	thet initieted events	Due to (or as a	consequence of):				
\$ 0 a €	resulting in death) Lest						
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the a de /	Pert II. Other algnificant conditions contributing			given in Pert I.	23b. Did to	Decco ues cont	tribute to the cause of death?
by bed by	End-stage re Peripheral va	nal dise	ease		1 🗆 Ye	a 2 No	3 Probably 4 Unknow
requirements should eted	Keripheral Va	scular o	isease		24a. Wes ar parform		24b. Were autopsy findings available prior to completion of cause of deeth?
The law ate has page 2:					1□ Ya	s 28 No	1 ☐ Yes 2 ☑ No
	25. Wes case referred to medical			26. Place of Dec	eth (Check only one	9)	
VISION Of VITAL Attending Physician: To deeth. ector: Attenthis centificate by the funeral director, pa iffication: To Be Co	examiner? 1 Yes 2 No Hospitel:	1 Inpatient 2 ER/O	outpatient 3 DOA	Othor	lome 5 ☐ Reside		r (Specify)
		Dete of Injury (Month, Dey Year) 28b.	Tima of 28c. (Injury et Work?	28d. Describe ho	w injury occurre	d
ondin seth. or: Af he tu	2 Accident investigation			1 ☐ Yes 2 ☐ No			
DIVISION (but or Attending P rs after deeth. at Director: After t ed in by the funers Certification:	3 Suicida 6 Could not ba determined 28e.	Plece of Injury - At home, foulding, etc. (Specify)	arm, street, fectory, off	ice	28f. Location (Str City or Town		r or Rural Route Number,
Division To the Hospital or Attending within 24 hours after deeth. To the Funeral Director: After completely filled in by the fun	29a. Certifier (Check only one) 1 Certifying Physician: T 2 Medical Examiner: On and	o the best of my knowledg he basis of examination a menner steted.	e, death occurred et th nd/or investigation, in r	e time, date and place ny opinion, deeth occu	, and due to the ca rred et the time, da	use(s) end men te end place, ar	ner as stated. nd due to the cause(s)
withir comp	29b. Signeture end title of certifiar			ense number			(Month, Day, Year)
	> Welfeleed	M.D	- P	11402	7	YLY 0	1, 1999
	30. Name and address of parson who completed WILLIAM IMBEAH, GO	cause of death (Item 23a)	(Type, Print) AN HOSPITAL	,5601 LO	H RAVE	N BLVD	, BALTIMORIE
State	31. Dete filed (Month, Day, Year)	32. Registrar's Signature	1				ND 21239

AH10



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First Middle Lest) 2. Data of Death 3. Tima of Death Day Year Month William Karl Palmer 10, 1999 3:40AM July 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 5650 Braxfield Road Arbutus Baltimore If Under 1 Yaar If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Months Days Hours 1 1 M 2 □ F 489-09-3826 82 3, 1916 Illinois Usual Rasidanca of Dacedant 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2 No Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5650 Braxfield Road 21227 U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White atc 1 Nevar Married 2 Married 1 Yas 2 No If Yes, Giva WWII White 1 ☐ Yas 2 ☐ No Specify: Specify 3 ☑ Widowed 4 ☐ Divorced Yaar or Datas 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cojlega (1-4or 5+) Wholesale Shoes Salesman 18. Mother's Neme (First, Middle, Maiden Surnama) 17. Father's Nema (First, Middla, Last) Jean Louise McNeil Harold K. Palmer 19a. Informent's Name/Ralationship (Type, Print) 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Palmer (Daughter) 5650 Braxfield Road, Arbutus, Maryland 21227 20b. Ptace of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition Dete 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from State Garrison Forest Cemetery 7/13/99 Owings Mills, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funarai Sarvice Licensaa 1630 Edmondson Avenue, Catonsville, MD 21228 emmer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert failure. List only one cause on each line. Approximata Intarval Between Onset and Death Immediata Causa (Final diseasa or condition rasulting in death) Dua to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contributa to the cause of death? 1 Yaa 2 No 3 Probably 4 thknown 24b. Were autopsy findings available prior to 24e. Was an eutopsy completion of cause of death? 1 Yas 2 Die 1 ☐ Yas 2 ☐ No 26. Place of Deeth (Check only ona) Hospital: Other: 4 Nursing Homa 5 Pasidence 6 Other (Specify)

Physician /Medical Examiner

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certificate

this funeral

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Completed

Be

Medicai Certification: To

The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

Division of Vital or Attending Physician:

Department of important: If any injury or page.

Physician

/Medical

Examiner

10a. State

Funeral

Director

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or Nerns

I Hygiene.

. Peges 1 and 2 should be fill ment of Health and Mental Hant: If item 27 is marked oth jury or other traumatic even

7 is marked other traumatic event,

"natural", or flem

Director

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death with the Maryland

filed within 72 hours after

21215-0020

altimore, Maryland

Examiner Sequentially list conditions, if any, laading to immadiate causa. Entar Undarlying Cause (Disaasa or Injury that initiated evants resulting in death) Last Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I.

25. Was casa rafarred to medical axaminar? 1 Yas 2 No

27. Manner of Death 5 Panding invastigation 2 Accidant 3 Suicida 4 Homicide

6 ☐ Could not be detarmined

1 Inpatient 28a. Data of Injury (Month, Day Year) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

1 critifying Phyalcian: To the best of my knowledge, death occurred et the time, dete and place, end due to tha cause(s) and manner as stated. 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b.	Signatura	and	titia	of	cartifia
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29e. Certifier

29c. License number

29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

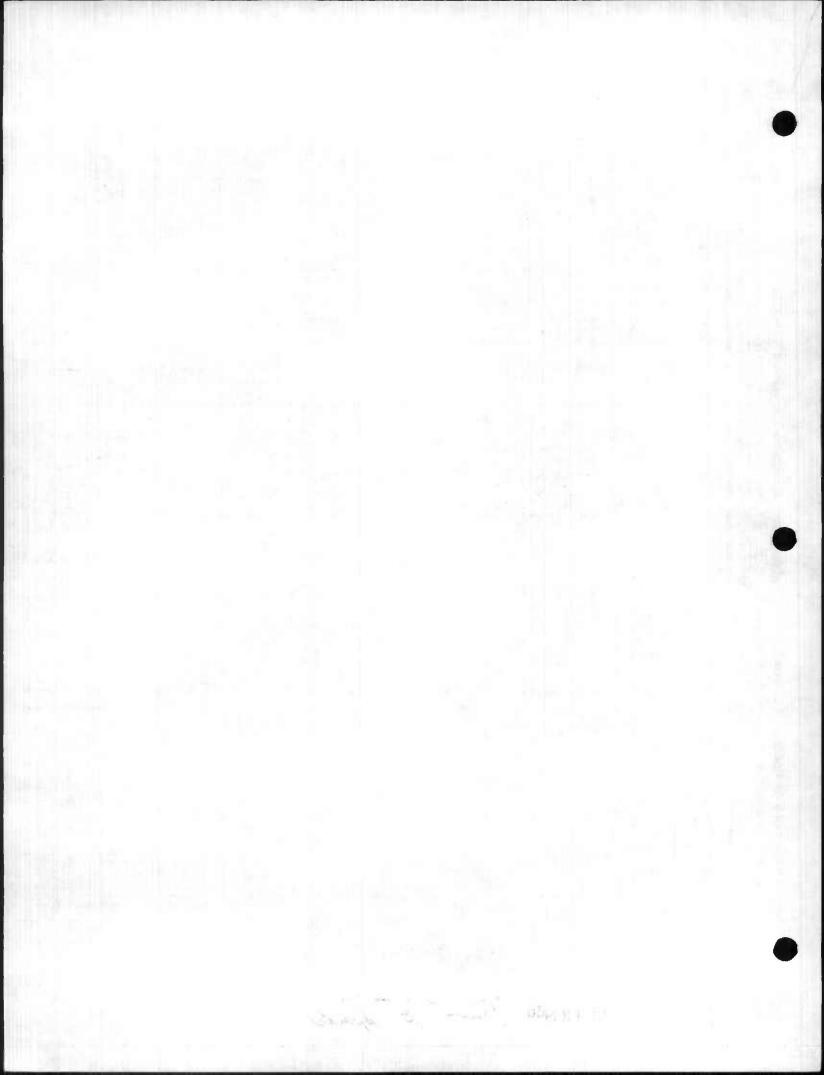
30, Nama and addrass of person

31. Data filed (Month, Day,

JUL 1 3 1999

32. Registrar's Signatu

State Registrar



ograb ITEM:		II, 27, 28A-	E PER ME) G	WR.	9Certifica	te of	Death		Reg. No.	99	21933
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miner	4a Facility Name	(If not institution, give	a street and number)			4b. City, Town, or			ty of Death	
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eral ctor	5. Social Security	1	ex M∑M 2□F	ge (In yrs. last b	Yrs. Months			. (Month, L	Day, Year)		laca (Stata or Foreign try)
OI .	Usual Residence		l	78				Oct.	17,19	20 Ma	ryland
rector	10a. Stata	10b. County			wn or Location					11	Od. Inside City Limits
cto	MD	Wicomi	CO	Sali	sbury						1 √Yas 2 No
Director	10s. Street and No					ip Code			10g. Citizen of	What Coun	try?
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Š	11. Marital Status	rried 2 Married	12. Was Decedent	?	If Yas, spe	ecify Cub	Hispanic Origin? (S pan, Mexican, Puer	to Rican, atc.)		ace - Amaric ack, White,	
by	4.6	4 Divorced	1 ☐ Yes 257 If Yes, Give Year or Dates:		1 🗆 Yas	2⊠ No	Specify:		Speci	''y∵ Whi	te
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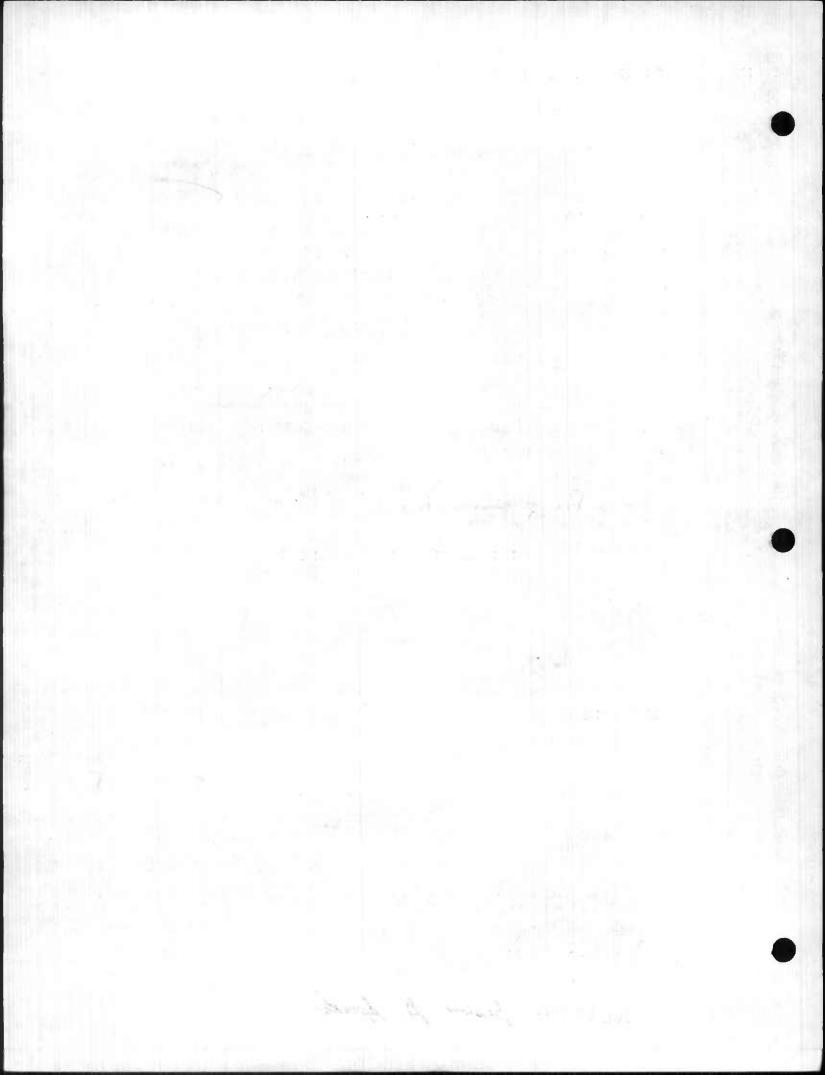
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10e. Street and No	1.			10f. Zip Code			10g. Citizen of W	/hat Country?
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Please Type or Print in Black indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death JUL Y 1999 Robert Morgan Poist, Sr. 12:30 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1413 Kuper Street N/A Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) JAN. 30, 19 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1QM 2□ F Months Deys Yrs Maryland 1937 213-34-5007 Usual Residenca of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Ves 2 □ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1413 Kuper Street 21223 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 Yes 2 X No Specify: 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Taylor Basin Presser 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Robert James Poist Eva Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2601 Myrtle Avenue, Balto., Md. 21227 Bonnie Poist/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 20a. Method of Disposition 7/12/99 1 X Burial 2 ☐ Cremation 3 ☐ Removel from State Loudon Park Cemetery Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 21. Signature of Auneral Service Licanses veror 7250 Washington Blvd., Elkridge, Md. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shook, or heart failure. List only one cause on each line. Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Myocardiac Infaretion Due to (or es e consequence of): Emphysema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Hyper tension Due to lor as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) 1□ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident

Records, P.O. Box 68760 Division of Vital **Physician**

/Medical

Examiner

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Funeral

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the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel; or Items 23a or 28a4 showeny injury or other treumatic event, the Maryla Example must have not a

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/Medical Examiner

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Hospital or Attending Physician:

altimore, Maryland 21215-0020

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State Registrar

31. Dete filed (Month, Day, Year)

29b. Signeture end title of cartified

3 Suicide

29a. Certifier

4 Homicide

(Check only one)



281. Location (Street and Number or Rural Route Number, City or Town, State) 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, end due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

18454

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

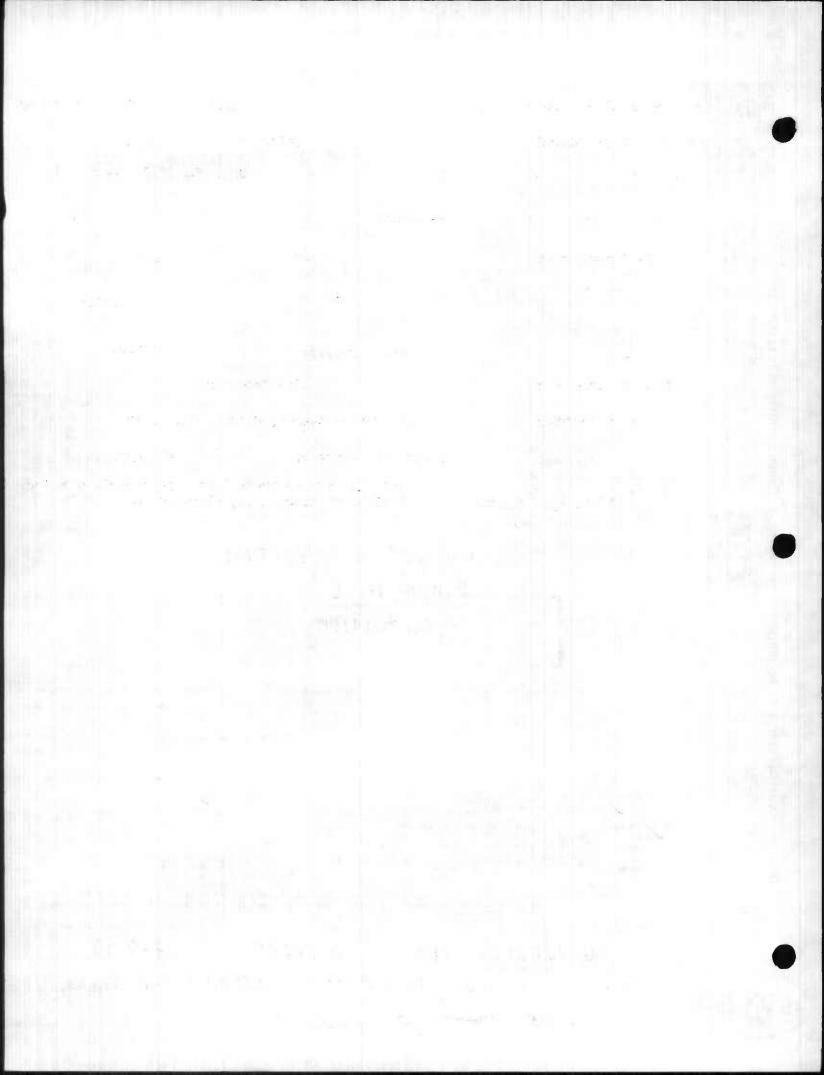
1910 W. Pratt. St. Baltimore MD 21223.

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

SUCHADA U. SAPSIRI

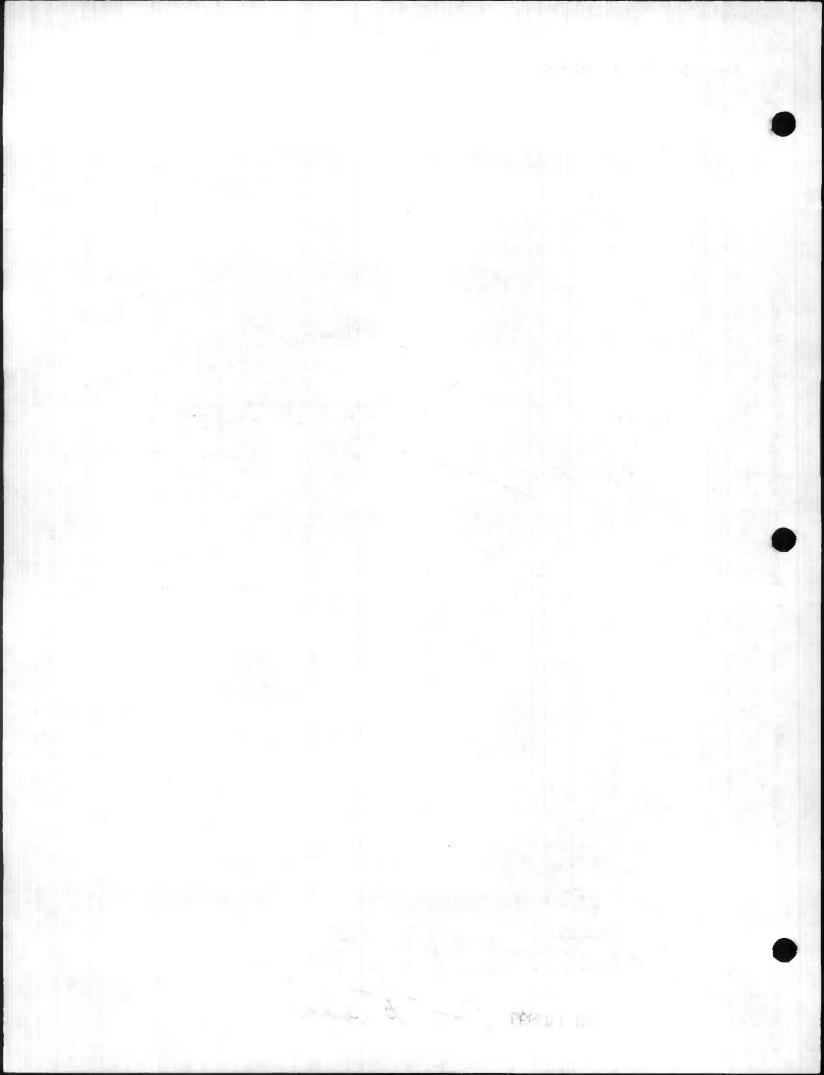
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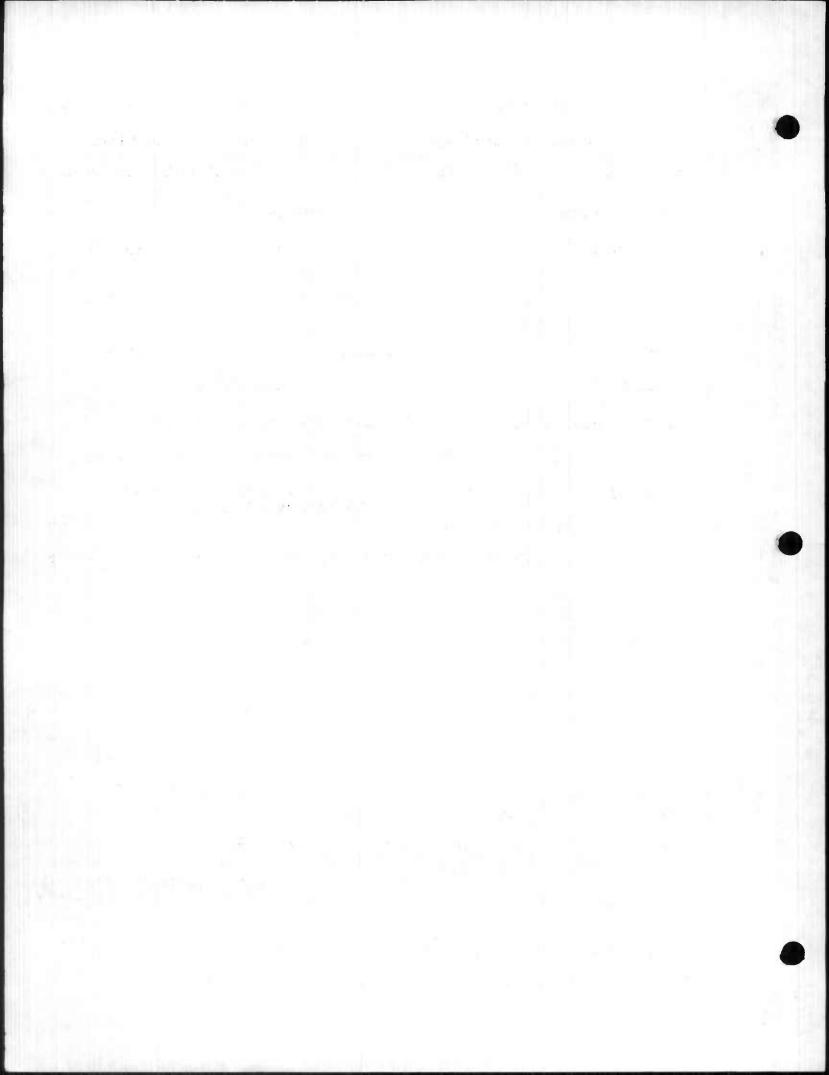
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/Medical Examiner	4a Facility Nama (If not institution,)			4			July cation of Deat	4c. Coun	ty of Death	3:11 P.M.
Funeral Director	Mercy Medical (5. Social Security Number 215-42-0293		ga (In yrs. Ia 55	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Data of Bir (Month, Da	th	9. Birth	placa (State or Foreign ntry) GA
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any injury	21. Signature of Funeral Service Lic	ensee			2. Nama an							OS., INC. MD 21208
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To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29e. Certifiar 1☐ Certifying I (Check only one) 2☑ Medical Ex	Physician: To the best aminer: On the basis o end manner st	f examinetic	ledge, deetl on and/or in	n occurred ovestigation,	et the tim	ne, date ar pinion, dea	nd place, a	and due to the ed at the time,	cause(s) and r data and place	nenner as :	stated. to the cause(s)
Comple	296. Signature and this of certifier	me, M	. D p	les Dr.	Chest		o number	Ε.		29d. Dete sign		
U	Dennis Chute M.I 31. Data filed (Month, Day, Year)).				enn :	Stree	t, B	altimor	re, Mar	yland	21201
State egistrar	JUL 1	3 1999	ar's Signatu	1	9. 1	pa	Ks					



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			1	State o	if Marylai			ent of F ate of			lental Hyg R	iene eg. No.	9	41900
	ysicia Medic		1. Decedent's Name (First, Middle LINDA J	e, Last) ROBERTS(ON						2. Date of Dear Month JULY 1		9 ^{Year}	3. Time of the th
	amin	_	4a. Facility Name (If not institution	The second second		1		4	- 1		ocation of Death	4c. Count		
-		-	Franklin S 5. Social Security Number	quare Ho	7. Age (In yrs) If Un	der 1 Year	ROS If Under	seda	1 L C 8. Date of Birth		1tim	
Fund Direc			235-60-5493	1 □ M 2 □X0F	5		Month	ns Days	Hours	Min.	(Month, Day NOV • 9	1940	West	lace (State or Foreig Virginia
pug *			Usual Residence of Decedent 10a. State 10b. County		10c C	ity, Town or L	ocation							0d. Inside City Limits
Maryla	ned at	to	Md. Balt:		1,55. 5	.,,		Pa	rkvi1	1e				1 □ Yes 2 No
h with the	at be not	ai Director	10e. Street and Number 3329 Garnet	Road			10f.	Zlp Code	2123	4	1	0g. Citizen of	What Cour JSA	ntry?
15-0020 in 72 hours effer death with the Maryland "natural", or items 23a or 28a-f ahow	Examiner my	by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☒ Widowed 4 ☐ Divorced	Armed For led 1 ☐ Yes If Yes, Gir	2 2 No	J,S. 13.		cedent of H pecify Cuba 2 X No	lispanic Origan, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ck, White, y: W	
15 n 72	the Medical	Completed	Elementery/Secondary (0-12)	t's Education st grade completed) College (1-4or 5+)				ation during mosi d)	t of worki	ing	16b. Kind of B		
		Be Co	9th 17. Father's Name (First, Middle,	Last)			nome	maker		er's Name	e (First, Middle, I		n home	3
Maryland d 2 should be file th end Mental Hy T is marked othe	atic ev	ToB	Trevy Cave	2						Mary	Phares			
20 0	Eng.		19e. Informent's Name/Relations								Route Number			Code)
m 2	other	-	Lance Robertso 20a. Method of Disposition	on / son	20b.	Place of Disp	osition (/	Vame of		Aper	deen Md	20c. Location		wn, State
Page Page nent of	ry or		125 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			ak LAw			y 7/	14/9	9	Baltin	nore 1	Md.
Baltimore, N permit. Pages 1 and Department of Health Important: If Item 27	any inju		21. Signature of Funeral Servica	(b	00			Conne	ss of Facilit	imer	al Home	of Ess	sex	
110		7	23a. Part1. Enter the disease, or shock, or heart teilure. List	complications that complications cause one	aused the dea	th. Do not en	nter the m	300 M node of dyin	ace A	Ve.	Baltimo or respiratory arr	re Md.	2122	Approximate interval Between
Physic /Medi Exami	icai		Immediate Cause (Finei disease or condition resulting in death)	· Ano	phyla	xis -	Bllo	wm	0		sting			3 days
8 / 6U, cate be executed		i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or Injury	b		or as a conse								
OX O	5	be	thet initiated events resulting in death) Last	d	Due to (or as a conse	quence o	of):						
death	led for	Physician/M	Part II. Other significant condition	ns contributing to de	eath but not res	suiting in the	underiyin	g cause giv	en in Part I.		23b. Did to	bacco uae co	entribute to	the cause of death
that the de	detach										1 □ Y	2 No	3 Prol	bably 4 Unknow
cords, requires been sign	2 .	Completed by									24a. Was a perform	n autopsy ned?	av	ere autopsy findings ailable prior to mpletion of cause death?
The law	page	E 0									1 🗆 Y	s 2 No	10	Yes 2□ No
Of VICAL Physician: The this certificate	ector	Be Be	25. Was case referred to medical examiner?	Hospitel:				Oth		of Death	(Check only or	e)		
- 2 w	0	2	12 Yes 2 No 27. Manner of Death	28a. Date	of Injury	ER/Outpatie			4 LI NU	1	me 5 Reside			y)
VISION Attending r death. bctor: After	e fun	atior	1 ☐ Natural 5 ☐ Pendin 2 ☐ Accident investig	9	7, 1999	Injury	PM	28c. Injur Wor	k? Yes 2 💢		Bee Al	m(
DIVISION O al or Attending Ph s efter death. i Director: After th	ad in by th	Certification:	3 ☐ Suicide 6 ☐ Could a determined	ined 256. Place	of Injury - At h	ome, farm, si		ory, office			City or Town	n, State)		Route Number,
To the Hospital or A within 24 hours effer to the Funeral Dire		edicai	29a. Certifier 1 Certifyin (Check only one)	g Phyaician: To the Examiner: On the be	best of my kno asis of examina ner steted.	owiedge, deal ation and/or Ir	th occurrenvestigati	ed at the tin	ne, date an plnion, deal	d place, i	and due to the co	ause(s) and m	anner as s	lated. 2/274
ro the	ydwoo		29b. Signature and title of certifie		ioi sidieti.		T	29c. Licens	e number		2	9d. Date signe	ed (Month,	Day, Year)
F > F ("		J. Crosson	Obnara	m, M	. D.		Do	763	2		July	13,	1999
			30. Name and address of person	4				LY A	UIS	BA	1 TO m	0	1223	- Madingly
	State		J. CROSSAN O DON 31. Date filed (Month, Day, Year)	32, R	egistrar's Sign		ADA	- M	VE.,	D14	L10 1/(5 4	the de d	
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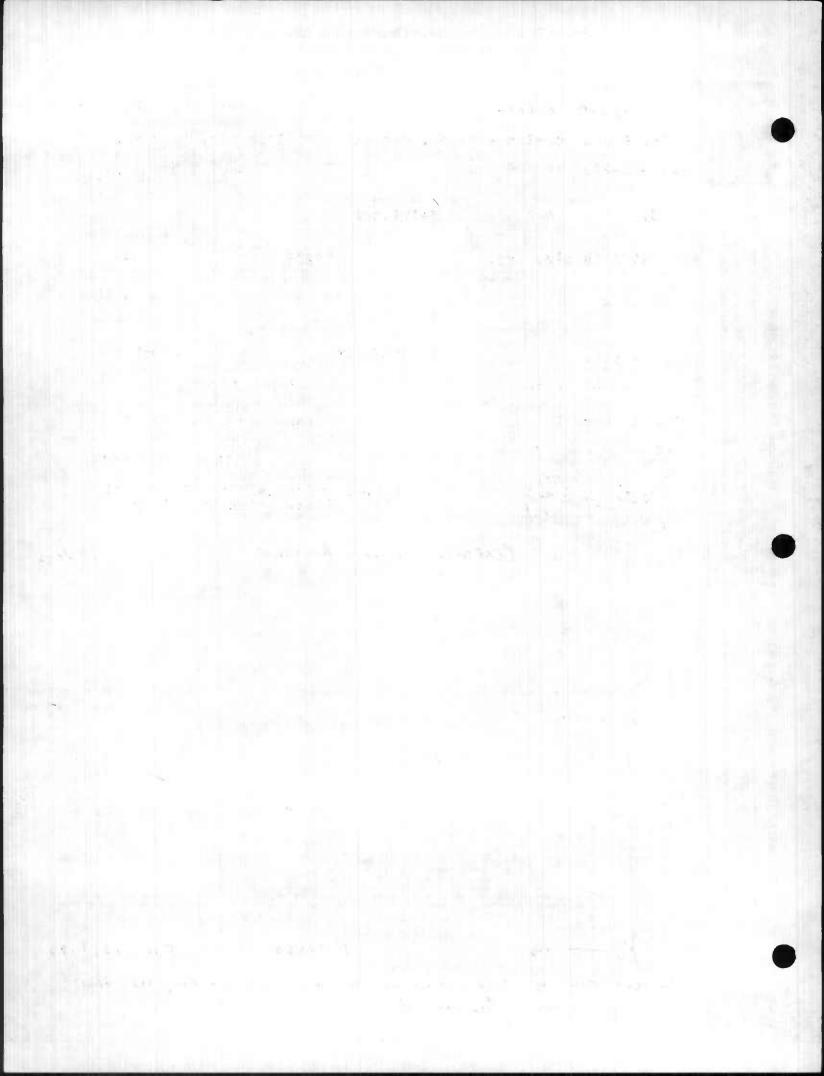
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/Medica Examine	- 1	4a. Facility Name (If not Institution, give	e street and number)	Ho	Spita		Burning			07.0
Funerai Director		5. Social Sacurity Number 6. Social Sacurity Number 1 066-24-4769 Usual Residence of Decedent	ex 7. Ag □ M 2 3 F	e (In yrs. last b	Yrs. If Und Months	er 1 Yaar III Undar 24 Hi s Days Hours Mi		1929	9. Birthple Count New Y	aca (State or Foreign lry) OCK
how		10a. State 10b. County		,	wn or Location				10	Od. Inside City Limits
the Marylar 28a-f show ocurred at	Director	Indiana Porter C	٥.		Valpara	iso				1 ☐ Yes 2 No
terns 23a or 2		10e. Street and Number 410 Grandview	Ave.			46383		10g. Citizen of U.S.A.		ry?
urs aft	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowad 4 □ Divorced	12. Was Decadant Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Datas:			adant of Hispanic Origin? lecify Cuban, Mexican, Pue	(Specify Yas or No arto Rican, etc.)		ca - America ick, White, e fy: Whit	etc.
natural,	Completed	15. Decedent's Ed (Specify only highast grad		166	a. Decedent's Us (Give kind of w	rork done during most of w	rorking	16b. Kind of B		ustry
within she.	E	Elementary/Secondery (0-12)	College (1-4or 5		life. DO NOT	usa retired)		Board Rrgist		nn
77 70 1 10		17. Father's Name (First, Middle, Last)	N/A		Registra		ame (First, Middle			41
d 2 should be filed the and Mental Hyg 7 le marked othe traumatic event,	lo Be		own				hleen The			
2 shou end M le mari	-	19a. Informant's Name/Relationship (7	ype, Print)	19	b. Melling Addre	ss (Street and Number or I				Code)
od 2 lith e 27 le		Robert J. Rogers	Husband			dview Ave. Va				
of H		20a. Method of Disposition		20b. Place	of Disposition (Nature), crematory or	ame of	Date	20c, Location		
Peges nant of I int: if Ite		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				rematory July	13,199	Baltin	ore.M	arvland
permit. Pege Department of Important: if any Injury or once.		21. Signature of Funaral Service Licens	2 May	la	MCCul. 3204 M	and Address of Facility Ly—Polyniak I Mountain Road	Funeral E d Pasader	Home,P.A	and 2	1122
		23e. Part1. Enter the disease, or comp shock, or heart failure. List only of	olications that comed one causa on mon lin	the death. Do	not enter the mo	ode of dying, such as cardi	ac or respiratory a	rrest,		Approximete Interval Between
Physician /Medical		Immediate Cause (Final disease or condition	Res	oira	tory	Faile	124			Onsat and Death UNIS.
Examiner		resulting in death)	• (Due to (or es e	consequence of	FAIL				7.0
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entificate be ding physicis se as the bu	2	resulting in death) Last		Jue to (or as a	consequence of):				
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death ce	200	Part II. Other significant conditions co	ntributing to death bu	it not resulting i	in the underlying	cause given in Part I	23h Did	tohecco use co	ntribute to	the causa of death?
ed by the deteched	2		announg to death bu	it not rasuling i	in the underlying	cause given in Pan I.		Yes 2 No		
w s s								an autopsy rmed?	aval	re autopsy findings llable prior to apletion of causa eath?
The la	5						10	res 2000	10	Yes 2 No
ysician: The s certificate director, pag		25. Was case referred to medical examiner?				26. Place of De	eath (Check only o	ne)		
A SE D		1 Yes 2□ No	Hospital: 1 ☐ Inpatie		utpatient 3 D	OA Other: 4 Nursing	Home 5 ☐ Resid	denca 8 □Oth	er (Specify)	
Attending P r death. sector: After toy the funeral file of the fun		27. Manner of Deeth 1 Naturel 5 Pending 2 Accident investigation	28e. Date of Injur (Month, Day		Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	now injury occur	red	
Part I		3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Placa of Inju building, etc	ry - At home, fa . (Specify)	arm, street, facto	ry, offica	281. Location (: City or Tox	Street and Numb vn, State)	er or Rural	Route Number,
within 24 hours a To the Funeral Completely filled	2	Check only 2M Medical Exami	ner: On the basis of	examination ar	e, deeth occurred	d at the time, date and place, in my opinion, death occ	ca, and due to the	cause(s) and ma	anner as sta	ted.
the mple	-	One)	and mannar stat	ied.	1.1 00					
		29b. Signature and title of certifier	PR	Depu	0	DO60		29d. Date signe	1	
10	1	30. Name and eddress of person who co	ompleted cause of de	eth (Item 23a)	(Type, Print)	D060 645 A	meric	n 2	103	5-
State		31. Dete filed (Month, Dey, Year)	32. Registra	r's Signature	4					

MATHER P. Regard erry salve pet. all monday have some Lemmanne Miller March has been been Christians Grang January of Commenced Lawrence Black III I Stage Charter of the state

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State of Maryland / Department of Health and Mental Hygiene

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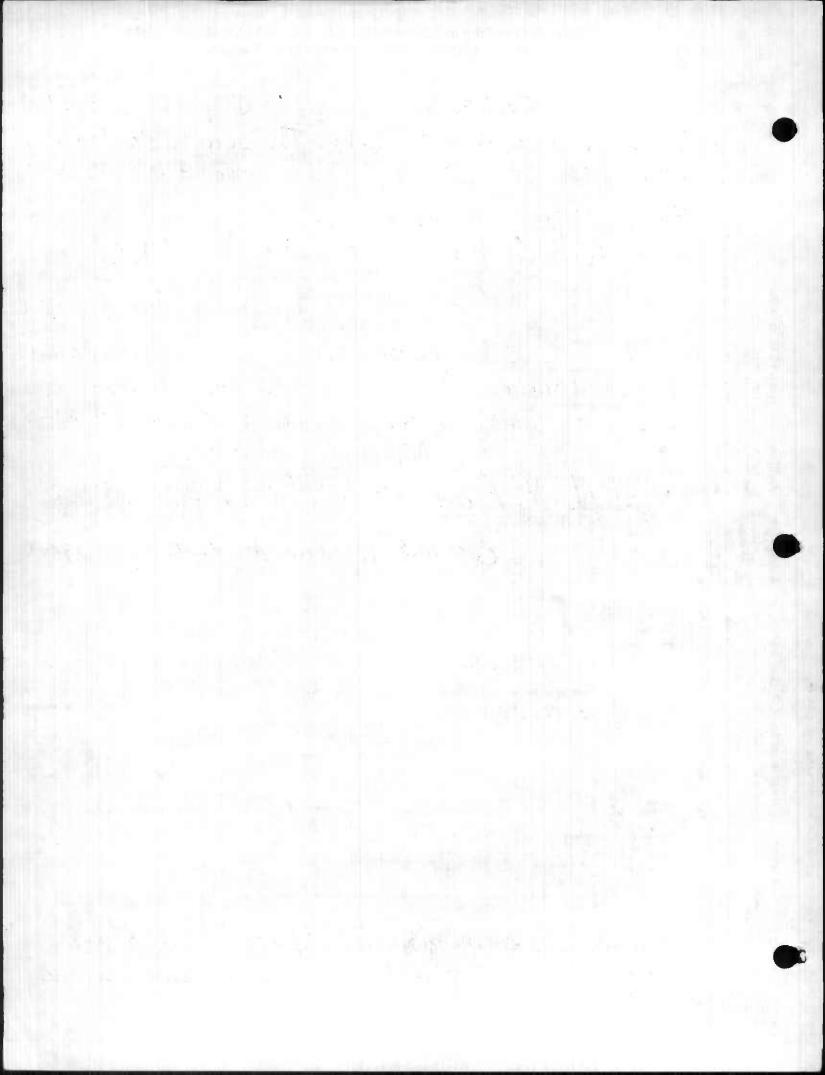
Registrar

31. Deta filed (Month, Day, Year)

1 3 1999

32. Registrar's Signatura

TOKIC HOUSE



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death 12 **Physician** 1999 0252 SCOTT HOWARD L JUL /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE HARFORD If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 180M 2□ F Yrs. 50 AUG 4 1948 MARYLAND Director 218-46-3661 Usual Rasidenca of Decedant the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or Itams 23s or 28s-f show traumstic avent, the Modical Examinat must be notified at 1 ☐ Yes 200No Directo MARYLAND HARFORD HAVRE DE GRACE 10a. Street and Number 10f. Zip Coda 10g. Citizen of What Country? illed within 72 hours after death with 237 BLOOMSBURY AVENUE 21078 U.S.A. Funeral 12. Was Dacedant Ever in U,S. Armed Forcas? 1 XXas 2 □ No If Yas, Giva Yaar or Datas: 67/70 Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, etc. 1 ☐ Never Married 2 ☐ Marriad Maryland 21215-0020 1 ☐ Yas 2 ☑ XSo Specify: Specify: BLACK þ 3 ☐ Widowad 4 ☼ Divorced Completed 18a. Decedent's Usual Occupation 16b. Kind of Businass/Industry 15. Decedant's Education (Giva kind of work dona during most of working lifa. DO NOT usa retired) (Spacify only highast grade completed) Hygiene. Elamantary/Secondary (0-12) Collaga (1-4or 5+) COMPUTER TECH. APG 12th grade 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maiden Surnama) Pages 1 and 2 should be fill ment of Health and Mental Heant: If item 27 is marked oth jury or other traumatic aven HOWARD L SCOTT JR VIRGINIA M SCOTT 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 21078 19a. Informent's Neme/Ralationship (Type, Print) 2001 Williams Drive, Havre de Grace, Maryland Barbara Scott/Wife Baltimore, 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data Burlai 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or pnce. 4 ☐ Donation 5 ☐ Othar (Specify) MT CALVARY UAME CHURCH 7-16-99 ABERDEEN, MARYLAND 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME-HARFORD
ARREST ARRESTS 321 S PHILADELPHIA BLVD ABERDEEN, MARYLAND 23a. Part1. Enter the disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause on each line. Intarval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition resulting in deeth) Medical ARDIAC SUDDEN Examiner Due to (or es a consequence of): PRDIOUASCULAR Examiner ERIOSELEROTIC (physicien and the burial-transit Sequantially list conditions, if any, leading to Immedieta causa. Entar Undarfying Cause (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequenca of) Box 68760, Physician/Medical Due to (or as a consaquenca of) 80 esn P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? BSTRUCTIVE PULMONARY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ 24b. Wara autopsy tindings availabla prior to complation of cause of death? 24a. Was an autopsy performed? INFECTION page 2 1 Yas 2 X No certificate 1 ☐ Yas 2 ☐ No Attanding Physician: 25. Was casa raferrad to medical axaminar? 26. Place of Death (Check only ona) Hospital: 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) Certification: To 1 ☐ Inpatiant 2 € ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day Year) 28c. Injury et Work? 27. Mannar of Daath 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Panding after death. Director: Aft 1 Yas 2 No Invastigation 2 Accidant 6 Could not be datarminad 3 Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of tnjury - At homa, farm, street, factory, offica bullding, atc. (Specify) 4 - Homicide 6 24 hours a 29a. Certifier 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

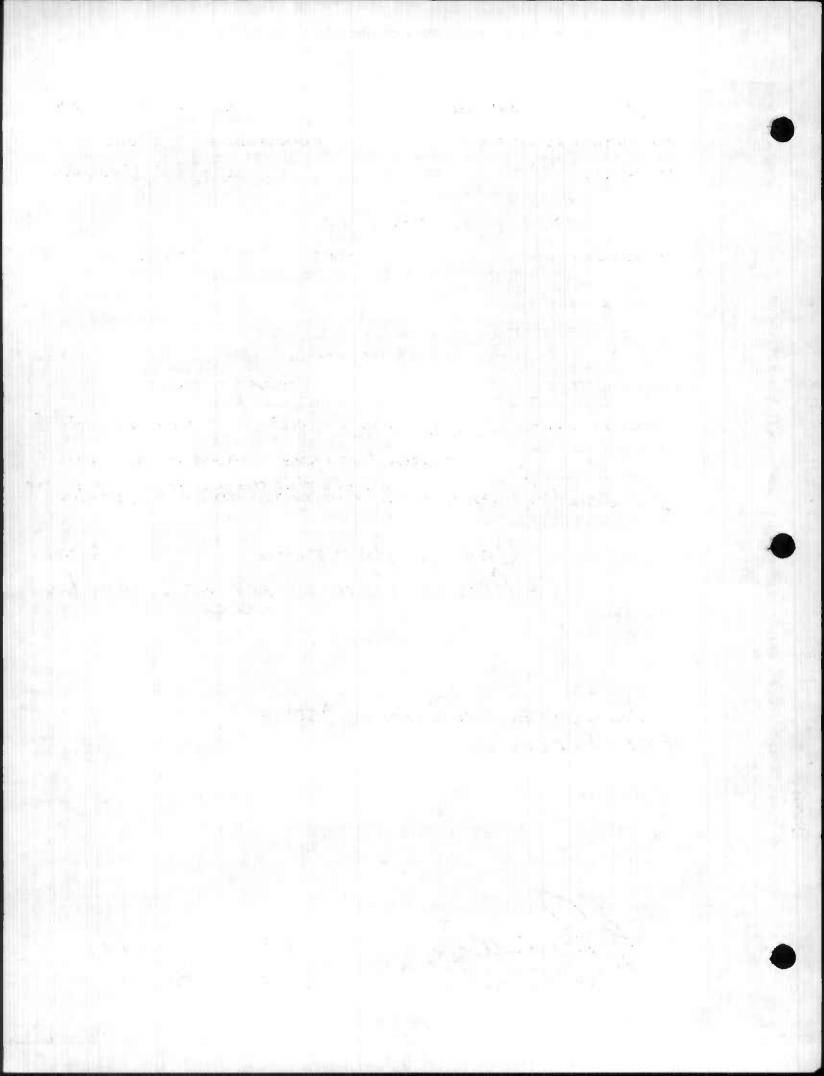
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the Medical (Check only one) ner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature i 29c. Licansa number 29d. Data signed (Month, Day, Year) OCME W ho complated causa of daath (Itam 23a) (Type, Print) SMIALEK 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State 3 1999 Registrar

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_	Decedent's Name (First,	Middle, Last)		Certificate	e of	Death	2. Date of De	Reg. No.	60 1	3. Time of Death
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/Medical	4a Facility Name (If not ins					4b. City, Town, or L	7		ty of Death	1.45 An
Examiner			•			Glen Burn			Arund	0.1
	5. Social Security Number	ne Nursing Co	encer 7. Age (In yrs. last b	introduct If Under		If Under 24 Hrs.				
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with the Maryta or 28e-f show be notified at Director		ltimore	Arbut							1 ☐ Yes 2 🖾 N
2 _4 =	10e. Street and Number 1538 Sulphu	r Spring Rd.		10f. Zip				10g. Citizen of United		
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and the	12	F12) College (1-	401 3+)	Owned C	omp	any		Excav	ating	
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Mental erked o ettic eve To Be	William Joh	n Schmelyun				Katheri	ne Mari	le Schae	efer	
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uny or oth	20a. Method of Disposition 1 Burial 2 Cremit 4 Donation 5 Ott	ation 3 Removat from S	tate cemet	of Disposition (Namery, crematory or of en Park C	her pla		Date -14-99	20c. Location		wn, State aryland
Department any injury and and and and and and and and and and	21. Signature of Funera Se	rvice Licentee	90			ess of Facility uneral Ho hur Sprin		Arbutus	s. MD	21227
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Examiner 5	resulting In death)	a. <u>* Y</u>		consequence of):			7.7			0
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within To the comple	29b. Signature and title of c	ertifier	, , ,	29c	Licens	se number		29d. Date sign	ed (Month,	Day, Year)
r	Whynia	em Atten	due De	etar	D	21689	1	7-12	2-19	55
	30. Name and addrass of po	erson who completed cause	of death (Item 23a)	(Type, Print)	Ko	Y, PASA	DENA	, mo	2112	۲. ۲
State Registrar		1 3 1000 32. Re	glstrar's Signature	4 %	- 11	/ /				

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State of Maryland / Department of Health and Certificate of Death	Mental Hygiene	99	21
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/Medical	BUCON	PANC
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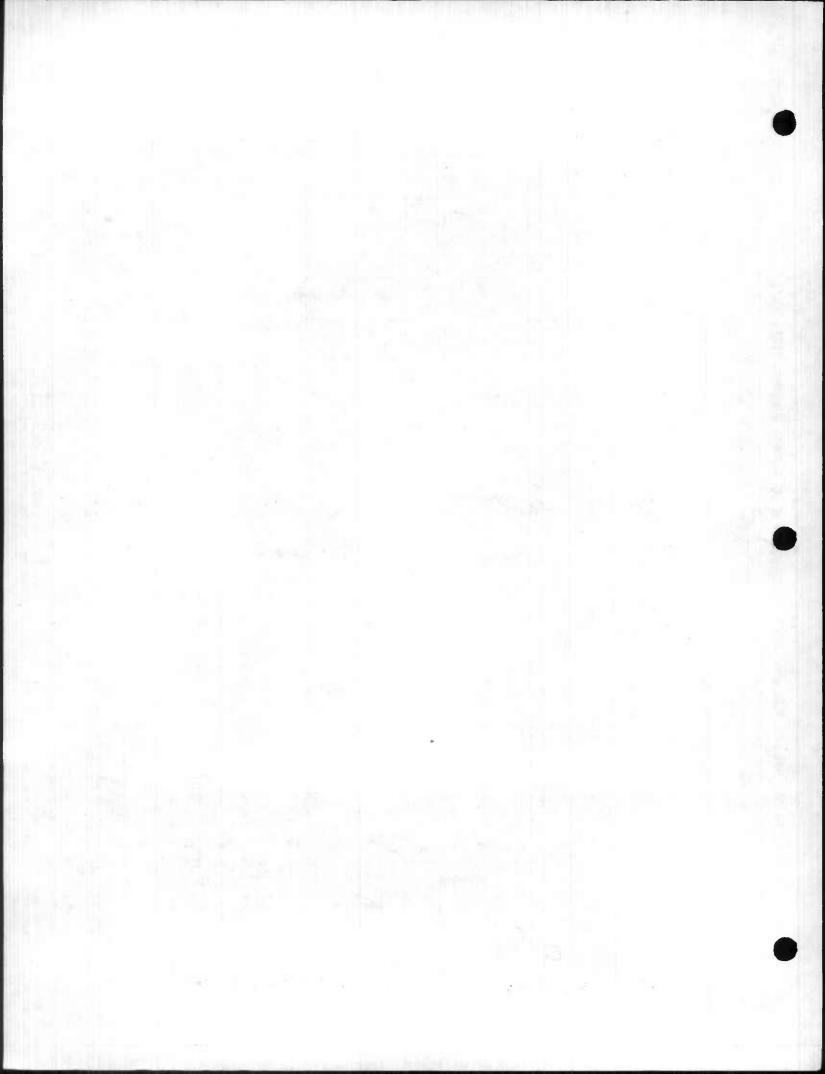
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lan)	2 sho and N	T.	t9a. Informant's Name/Ralationship (Ty	pe, Print) 19t	. Mailing Addras	s (Street	and Number or R	ural Routs Number	City or Town,	Stata, Zip Coo	le)
	teath m 27 her tr		VAlerie Black	5	2030	5. E	Ager	St. BAH	inve,	MD. S	11205
more,	H of H		20a. Mathod of Disposition 1. Burial 2 □ Cramation 3 □ R	comete	t Disposition (Nary, cramatory or	other plac	θ)	Data	20c. Location	City or Town,	Stata
=	ortant Injury		4 □ Donation 5 □ Other (Specify) 21 Signature of Funeral Service License	DAlti	22 Names	(e)	s of Facility	111>175	D4 14	INOKE	, MD.
Ba	Dep limps		Auchle 1	mattelee	112	9 N.	CAro	line st	. BAH	tom	21213
			23a. Pan J. Entar tha diseasa, or compli shock, or heart failura. List only or	cations that caused the death. Do no cause on each fine.	not antar tha mo	da of dyin	g, such as cardia	c or raspiratory arm	ıst,	Inta	roximata rval Batween
	Physician /Medical		Imrediata Causa (Final			1-	1			Ons	sat and Death
	Examiner	П	disaasa or condition rasulting in daath)	Gunshot Wa			chest			I	
		ner		Dua to (or as a	consequence of):				1	
	death certificate be asscuted to attending physician and ed for use as the burial-transit	Examiner	Sequentially list conditions,	Dua to (or as a	consequence of):				1	
60,	be ax	B E	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
68760	phys s the	odic	that initiated evants rasulting in death) Last	Dua to (or as a	consequance of	:					
Вох	nding use a	N.									
Ö	death e atte	siciar/Medical	Part II. Other algnificant conditions con	tributing to death but not resulting i	n tha undarlying	causa giv	en in Part I.	23b. Did to	bacco use co	ntributa to the	cause of death?
O.	v requires that the been signed by th should be detach	Phys			, ,			1 🗆 Y	2 No	3 Probabl	y 4 □ Unknown
Ś	signed bed	by								T 045 141-1-1-1	Anna dia dia a
Ö	law requires that the as been signed by the 2 should be detach	Completed by		•				24a. Was a perforr		comple	utopsy findings le prior to tion of cause
Ř	S 00	дшо						1670	ıs 2□No	of deat	
Ta Ta	ysician: The la is certificate he director, page	Be Co	25. Was casa rafarred to medical				26 Place of De	ath (Check only on		i gerra	8 2□ No
≥		ToB	examinar?	lospital:	utpatient 3000	Oth	D/*-	loma 5 ☐ Raside		nar (Specify)	- 13
0	ding Phys h. After this funeral di		27. Mannar of Death 1 □Natural 5 □ Panding		Tima of Injury	28c. Injun Worl	at c?	28d. Describe ho		1	
Sio	Attending or death. ector: After by the fune	cati	2 Accidant invastigation 3 Suicida 8 Could not be		7:14 M		Yas 2 No	545/		hot	
Division of Vital Records,	X445	Certification:	4 Homicide datarmined	28a. Place of fnjury - At homa, fa building, atc. (Specify)	arm, street, facto	ry, office			, Stata) Wi	oer or Hural Ho	
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certitiar 1☐ Certifying Phys	Sweet- ifclan: To the best of my knowledge	a, daath occurre	d at tha tim	a, data and place	Small s, and dua to the ca		annar as stated	1.
	n 24 h	edicai		ner: On the basis of examination an							
	To the Comp	ž	29b. Signatura and titia of certifiar	08/1	29	9c. Licans		2	-	d (Month, Day,	Year)
			· E	100		O.C.	M.E		JOLY 1	1,1999	
			30. Nama and addrass of person who co	mpleted causa of death (Item 23a)		Pon	n Stroot	, Baltim	nre Ma	fore form	21201
			Dana R P	UNU	LL.	LCI	" DITEGE	· A DOTTIN	DIE, LIC	LL Y LOUR	ZIZUI

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State

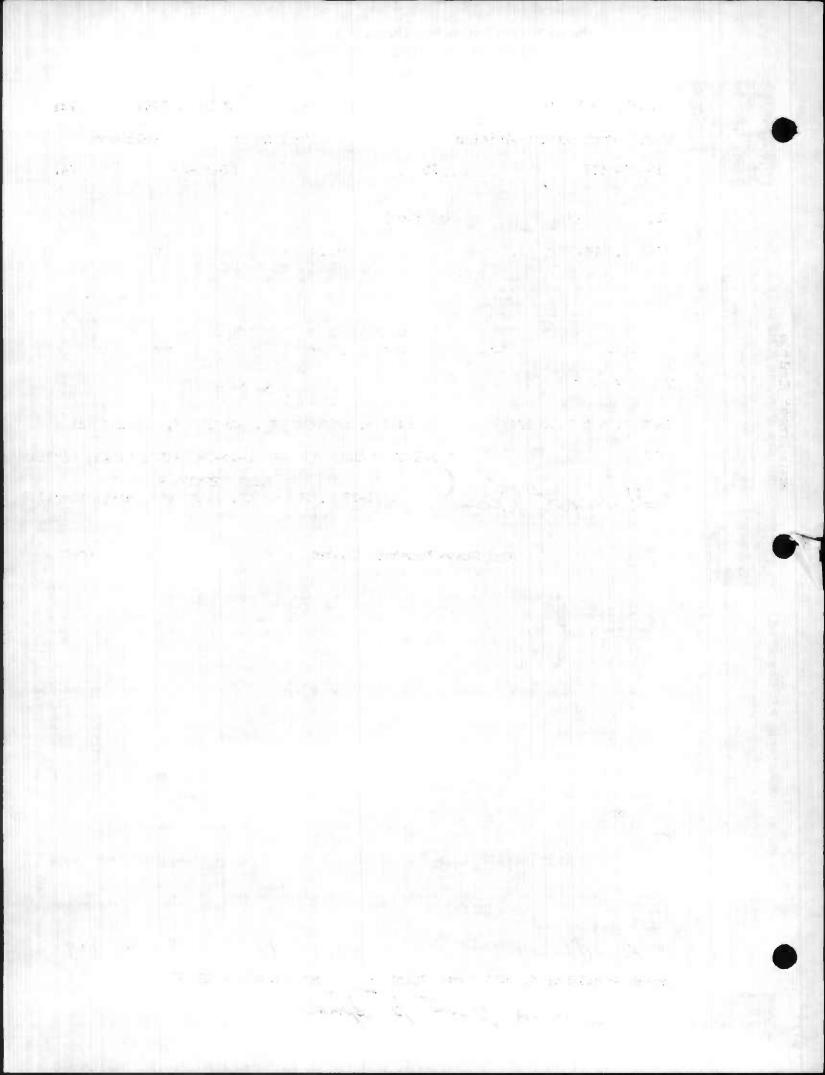
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32. Registrar's Signatura



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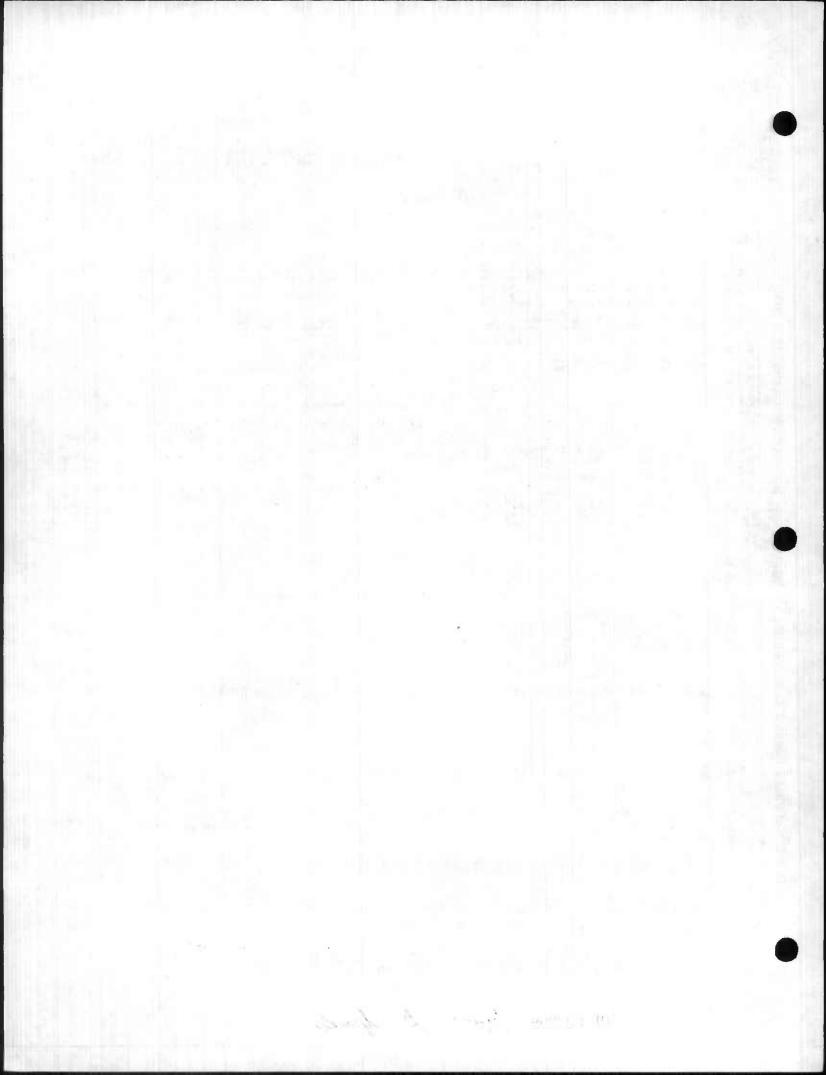
cian	Decedant's Nama (First, Middla, Last)						ificate of		2. Data of De	Reg. No.		3. Time of Death	
dical		ST SHELT							Month July	9, 199	9 Year	8pm	
iner	4a Facility Name VAMHCS		o, giva street and ward Di		n			4b. City, Town, or L Fort Hov			nty of Death	re	
	5. Social Security 215-16-		6. Sax 1 ★ 2 □		(In yrs. last 78	Direction of	If Undar 1 Yaar Months Days	If Under 24 Hrs. Hours Min.	8. Data of Bi	rth ay. Year) -20	9. Birthp Cour	olaca (Stata or Foraign otry) VA.	
	Usual Rasidance of 10a. Stata	of Dacedant 10b. County			10c. City, T	own or Loca	itlon				1	Od. Inside City Limits	
Director	MD.	MD. N/A BALTIMORE										1 No 2 No	
	10e. Street and Number 1941 W. MULBERRY ST. 10f. Zip Coda 2122						23		10g. Citizan d USA	of What Coul	ntry?		
by runeral		rried 2 Marr 4 □ Divorced	Arme	Decedant E d Forcas? (as 2 No. No. No. No. No. No. No. No. No. No.			as Decedant of H as, specify Cub Yas 2 No	dispanic Origin? (Sp an, Maxican, Puart Specify:	pecify Yas or No Rican, atc.)	8	Race - Amari Black, White, cify: BLA	atc.	
	15. Decedant's Education (Spacify only highast grada complate Elamantary/Secondary (0-12) —12— Collage			ted) ga (1-4or 5-	16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) POSTAL SERVICE			king	16b. Kind of Businasa/Industry GOVERNMENT				
	17. Father's Name	17. Father's Name (First, Middle, Last)				PU5.	18. Mother's Name (First, Middle, Maiden Surname					1	
	JAMES SI					ob 11	Address (A)		WILLIA		Canal To	Code	
	19a. Informant's N							and Number or Ru					
	GRACE E. SHELTON(WIFE) 20a. Method of Disposition 1 \(\text{M} \) Burial 2 \(\text{Cramation} \) 3 \(\text{Ramoval from State} \) 4 \(\text{Donation} \) 5 \(\text{Othar} \) (Specify) 20b. Placa of Disposition (Nama of carmatory or other placa) 4 \(\text{Donation} \) 5 \(\text{Othar} \) (Specify) 3 \(\text{Ramoval from State} \) 6ARRISON FOREST VETERANS (7-15-99) OWING								20c. Locatio	on - City or To	own, Stata		
rnysiciarymedical Examiner	Immediate Causa disease or condition resulting in death) Sequentially list or if any, leading to it any, leading to causa. Enter Unc Causa (Disease othat initiated even resulting in death)	conditions, immediate derlying or injury	aF b c	1	Dua to (or as	rostat s a conseque s a conseque a conseque	ance of):	er				Years	
	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cau						larlying causa gi	a givan in Part I. 23b. Did tobacco use co			contribute t	ntribute to the cause of death?	
-								1	Yee 2□ N	o 3□Pro	bably 4 Unknown		
ŀ									24a. Wa	s an autopsy formed?	a	fara autopsy findings vallabla prior to emplation of causa death?	
									1 🗆	Yas 210 N	0 1	☐ Yas 2☐ No	
							Oti Doa Oti	26. Place of Dea	th (Check only oma 5□ Ras		Other (Cons	14 A	
2	25. Was casa rafa axaminar?			Minnetin	· 1 ED		3 DOA					197	
90 01		XNo ath 5 □ Pandin invastig 6 □ Could	Hospital: 28a. Control of the contr	1 inpatian Data of Injur Month, Day Place of Injur Duilding, atc	Year) 28	b. Tima of Injury	28c. Inju Wo M 1 at, factory, office	ry at rk?] Yas 2 No	28d. Dascribe	how injury oc		ral Roula Number,	
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State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death	Reg. No.	99 21946				
	Physician	Decedent's Neme (First, Middle, Last)	2. Date of Deeth Month Day	3. Tims of Death				
Ų,	/Medical	Bernard J. Sappe	June 29,1999	7:15 p.m.				
A	Examiner	4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Lo		ounty of Death				
		North Arundel Hospital Glen Bur 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Yeer If Under 24 Hrs.	nie Anr 8. Dete of Birth	ne Arundel Co.				
L	Funeral Director	212-36-4698 1 TM 2 F 61 Yrs. Months Deys Hours Min. Usual Residence of Decedent	(Month, Day, Year) Dec. 27, 1937	Birthplace (State or Foreign Country) Maryland				
	d 21215-0020 filed within 72 hours after death with the Maryland bygiene. ther than "natural", or thems 23a or 28a-f show int, the Medical Examiner must be notified at	10a. Stete 10b. County 10c. City, Town or Location Pasadena		10d. Inside City Limits 1 ☐ Yes 2 ☑ No				
		10e. Street and Number 108 Brookfield Road 21122	10g. Citizer U.S.	of What Country?				
21215-0020		11. Meritel Stetus 1 Never Merried 2 Merried 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 Never in U,S. Armed Forces? 1 Never in U,S. If Yes, specify Cuban, Mexican, Puerto If Yes, Sirve Yeer or Detes:		Race - American Indian, Bleck, White, etc. ecity: White				
5-0	led within 72 hours yglene. her than "natural", rt, me Medical E.	15. Decedent's Education 16a. Decedent's Usuel Occupation (Specify only highest grade completed) (Give kind of work done during most of work)	vorking 16b. Kind of Business/Industry					
121	jene. Tran	Elementery/Secondery (0-12) College (1-4or 5+) life. DO NOT use retired)	T. 07	0.00				
d 2	be filed with tital Hygiene. d other than event, me.	10 N/A Longshoreman 17. Father's Neme (First, Middle, Last) 18. Mother's Neme	I.T.O.Corp.					
Maryland	Saby W	James Sappe Anna	Hosey					
ary	E E E	19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rura		own, Stete, Zip Code)				
	12 mg	Charlotte A. Sappe Wife 108 Brookfield Road Pa	asadena, Maryl	and 21122				
Baitimore,	20 0 7 7	20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) 20b. Plece of Disposition (Neme of cemetery, crematory or other place) Cedar Hill Cemetery July 3,		ion - City or Town, Stete more, Maryland				
Sait	permit. Pag Department Important: I any Injury o pnsa.	21. Signeture of Funerel Servica Licensee 22. Neme end Address of Fecility McCully-Polyniak Ft	meral Home P	Σ				
ш	70 E # 9	John L. fellin 3204 Mountain Road	Pasadena, Mar	yland 21122				
	Chysician by Examiner by Physician and Medical Examiner burial-transit physician and a street burial-transit physician and a street burial-transit physician between the physician burial physici	shock or heart failure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last List only one cause on each line. CARD PURDAY AUEST Due to (or as a consequence of): Due to (or as a consequence of): C		Interval Between Onset and Death				
	eth certification of the use as							
P.0	that the ded by the detached	Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t.	23b. Did topacco use contributs to the cause of de					
Records,	been should		24e. Wes an eutopsy performed?	24b. Were autopsy findings eveilable prior to completion of cause of death?				
	The lay page 2		1 □ Yes 2 €	No 1 Yes 2 No				
	ysicien: The secretificate director, pag	25. Wes case referred to medical examiner?	h (Check only one)					
> >	5 60	1 ☐ Yes 2 M No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 M DOA Other: 4 ☐ Nursing Ho	ome 5 Residence 6	Other (Specify)				
	Attending Ph or death. ector: After th by the funeral	1 Montantal 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No	28d. Describe how injury occurred					
ā	bal or Attending P is after death. el Director: After to led in by the funer: Certification:	3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, State)					
	n 24 hours he Funer pletely fill edical	29e. Certifier (Check only one) 11 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, 2 Medicat Examiner: On the basis of examination and 2 Medicat Examiner: On the basis of examination and 2 Medicat Examiner: On the basis of examination and 3 Medicat Examiner: On the basis of examination and 3 Medicat Examiner: On the basis of examination and 3 Medicat Examiner: On the basis of examination and 3 Medicat Examiner: On the basis of examination and 3 Medicat Examiner: On the basis of examination and 3 Medicat Examiner: On the basis of examination and 3 Medicat Examiner: On the basis of examination and 3 Medicat Examiner: On the basis of examination and 3 Medicat Examiner: On the basis of examination and 3 Medicat Examiner: On the basis of examination and 3 Medicat Examiner: On the basis of examination and 3 Medicat Examiner: On the	red at the time, date end pla	ace, and due to the cause(s)				
	within Tour	29b. Signeture and thile of certifier 29c. License number 29c. License number	29d. Dete s	Igned (Month, Dey, Year)				
	1081	30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 844 RACH'E HWY. Str. 206 SEVERNA PALK	MD 211	46				
	State Registrar	31. Dete filed (Month, Day, Year) 32. Registrer's Signeture JUL 13 1999 Kenne & South						



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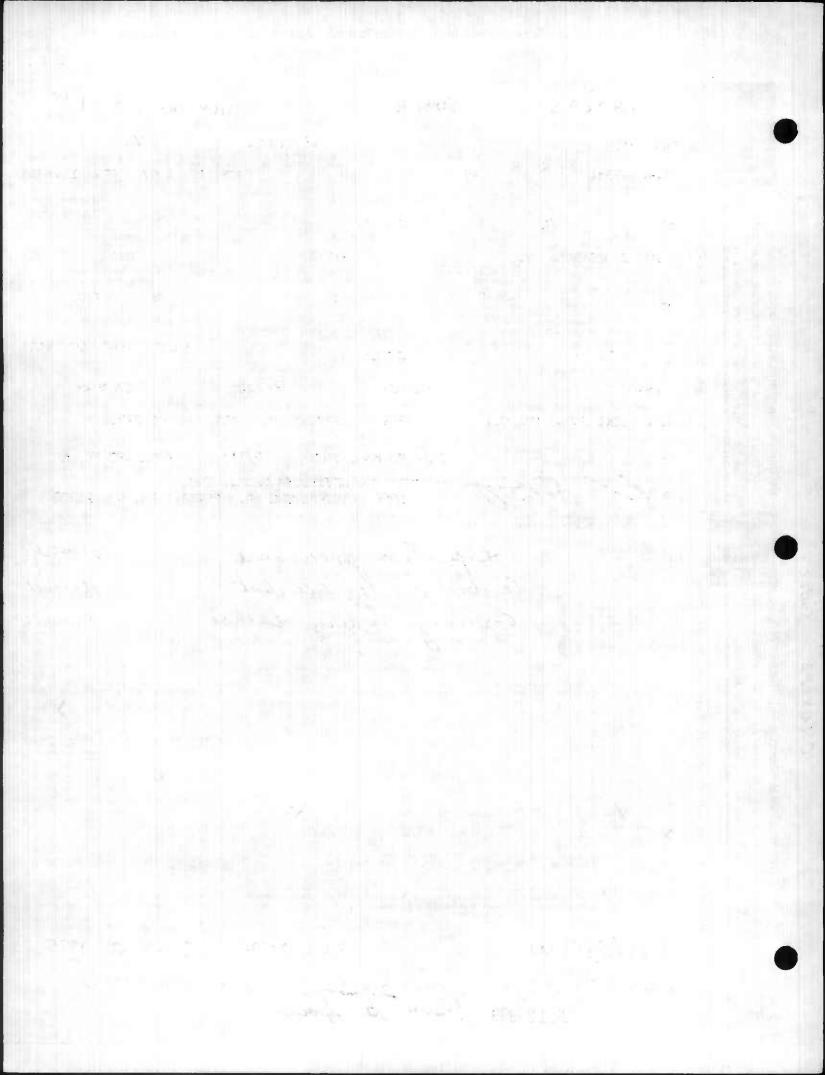
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SUBLE 04.1999 CHARLES JULY. /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner BALTIMORE N/A LEVINDALE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** XOM 2□ F Months Days Hours Yrs. 111-05-5841 19, 91 1907 PENNSYLVANIA Director Usuel Residence of Deceden the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-f ahov other traumatic event, the Medical Examiner must be notified at Yes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? with 4100 N. CHARLES ST. 21218 USA death Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Raca - American Indian. Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after of Department of Heelth and Mentel Physiena. Important: If Item 27 Is marked other than "natural", or Item 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Merried 2 Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LADIES READY TO WEAR OWNER 12 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) ISAAC SOBLE MOLLIE **OBERMAN** 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MS. VICKI SOBLE (DAUG.) 6709 CHOKEBERRY RD. BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Buriel 2 Cremetion 3 Removei from State 4 Donation 5 Other (Specify) 6 7/11/99 BETH EL MEM. PARK RANDALLSTOWN, MD any Injury 21. Signature of Juneral Service Licensee 22 Name and Add INSON BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In deeth) /Medical **Examiner** Examiner el maula physician and the bunel-tran Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Records, P.O. Box 68760, Physician/Medical e consequence of) use as I 23b. Did tobacco use contribute to the ceuse of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 6 signed b by 24b. Were autopsy findings aveilable prior to 24a. Wes an autopsy performed? Completed completion of cause of death? page 2 s hes 1 Yes 2 No certificate Division of Vital or Attending Physician: director, 25. Wes cese referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 5 Pending death. 1 Yes 2 No investigation 2 Accident ofter death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours e Hospital 12 Cartifying Physician: To the best of my knowledge, death occurred et the time, date and piece, and due to the cause(s) and manner as steled.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Certifier edical (Check only one) To the within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) Willedere aue,

2434

32. Registrar's Signature

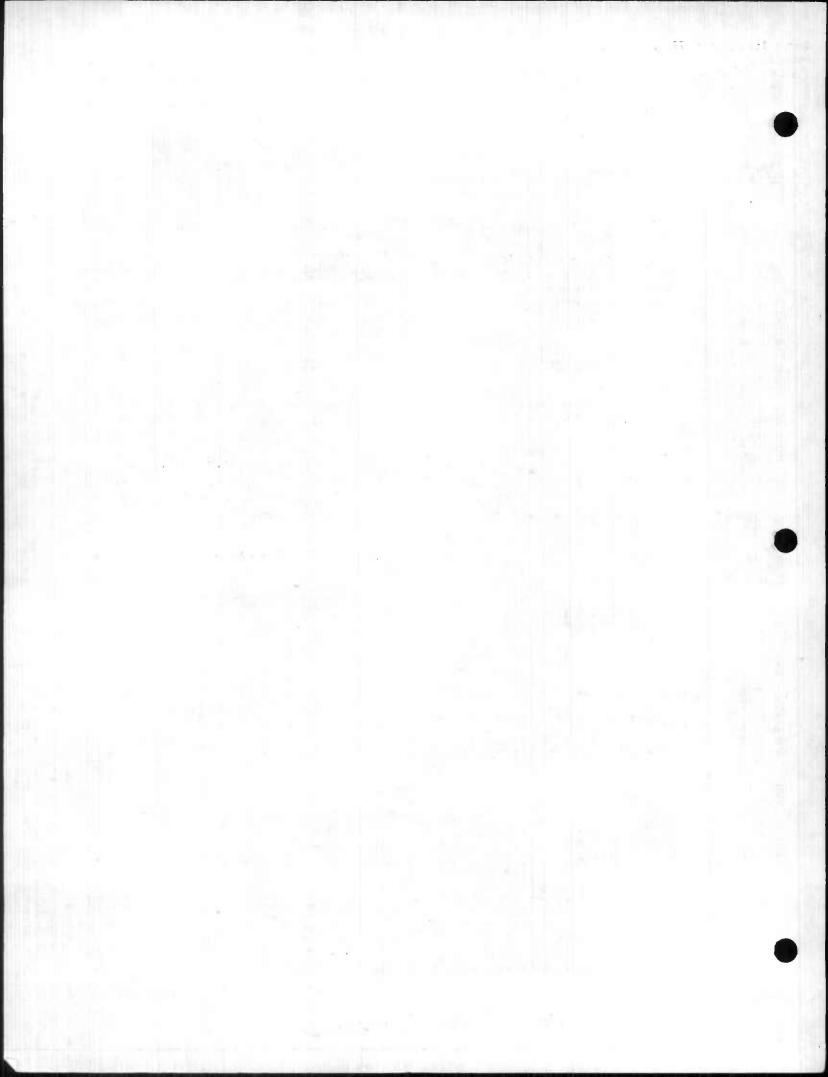
JUL 1 3 199**9**

State Registrar 31. Date filed (Month, Day, Year)



CH	State of Maryland (Department of Health and Marylan								Reg. No. 77 - 2/970									
	1. Decedent's Nam MORT		LAN SI	V V/20	2D 170			2. Data of De Month	Day	Yaar	3. Tima of Death							
			ive street and number		BEILL	1	4b. City, Town, or I	ocation of Deat		1999 ty of Death	3:00PM							
	3353 C	HESTNUT	AVENUE				BALTIMO	RE	N/	Α								
	5. Social Security N	- T	Sex 7. Ag	ge (In yrs. la	st birthday)	If Under 1 Yas Months Day	ar If Undar 24 Hrs.	8. Data of Bir	th y, Year)	ear) 9. Birthplace (State or Foreig Country)								
213-30-1933 TURM 2LIF.					173.			03-05-	03-05-1933 M		YLAND							
ľ	10a. Stata	10b. County			ity, Town or Location						10d. Inside City Limits							
ŀ	MARYLAND	N/A		BALTIMORE						1140-1	1 Yas 2 No							
	10e. Street and Nu		ATTENTITE			10f. Zip Code 2121			10g. Citizan o		intry?							
-	11. Merital Status	CHESTNUT	12. Was Decedent				alle .	lo- 14. Race - Amarican										
		ied 2 Merried		Armed Forces? 1 Yes 2 No		S. 13. Was Decedent of Hispanic Origin? (Specif Yas, specify Cuban, Mexican, Puarto R				Bleck, Whita, etc. Specify: TILITE								
-	3 Widowed	Λ.	Year or Dates:		15s Decedent's Heuri Occupation					W	HITE							
-		15. Decedent's l	rada completed)	completed)		16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business		loustry							
	Elementary/Second 12 Y		College (1-4or 5+)		CREW LEADER				CITY	OF BA	BALTO.							
	17. Father's Name		1)						(First, Middle, Maiden Surnama)									
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8900 REISTERSTOWN ROAD BALTO. MD 21208																		
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ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death July 9,1999 Day Thomas M. Small. Jr. 11:45AM 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Nursing Center Towsonne Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Dey, 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign Deys Months Hours 81 216-01-7546 10/19/1917 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Arnold 1 Yea 2 No 10e. Street and Number 10f. Zip Code 21012 10g. Citizen of What Country? 997 Forest Drive United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (M) No If Yes, Give Year or Dates: 11. Marital Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Firefighter Baltimore City Fire Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas M. Small, Sr. Emma L. Velten 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Carolyn Bengel/Daughter 3219 Ascot Lane, Fallston, Maryland 21047 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State 07/12/99 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, Maryland 21214 auco 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one ceuse on each line. Approximete Interval Between Onset end Death 3 Weeks Immediate Ceuse (Finel PEMPONITIS disease or condition resulting in death) Due to (or as a consequence of): HSTULA WOLONIC - VESICULAR Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest KNPTURED GWERTICULUM Due to (or as a consequence of Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ARTERY AGONSE WORNARY 1 Yes 2 No 3 Probably 4 Unknown MAINL FIBRILLATION 24a. Was an eutopsy performed? 24b. Were autopsy findings evailable prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical 26. Piece of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Dother (Specify) NO JO CE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 D Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital death

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Physician/Medical Completed by Be

Physician

/Medical

Examiner

Funeral

Director

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it of Health and Mental Hyg if Itam 27 is marked other or other traumatic event,

Department of Important: If any injury or

Physician /Medical

Examiner

Pagas 1 and 2 should be nant of Haalth and Mental

21215-0020

Baltimore, Maryland

Funeral Director

Completed by

Examiner Certification: To after deat • Funeral

1 Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certified

99c. License number 930433

use of death (Item 23a) (Type, Print) 6701

31. Date filed (Month, Day, Year)

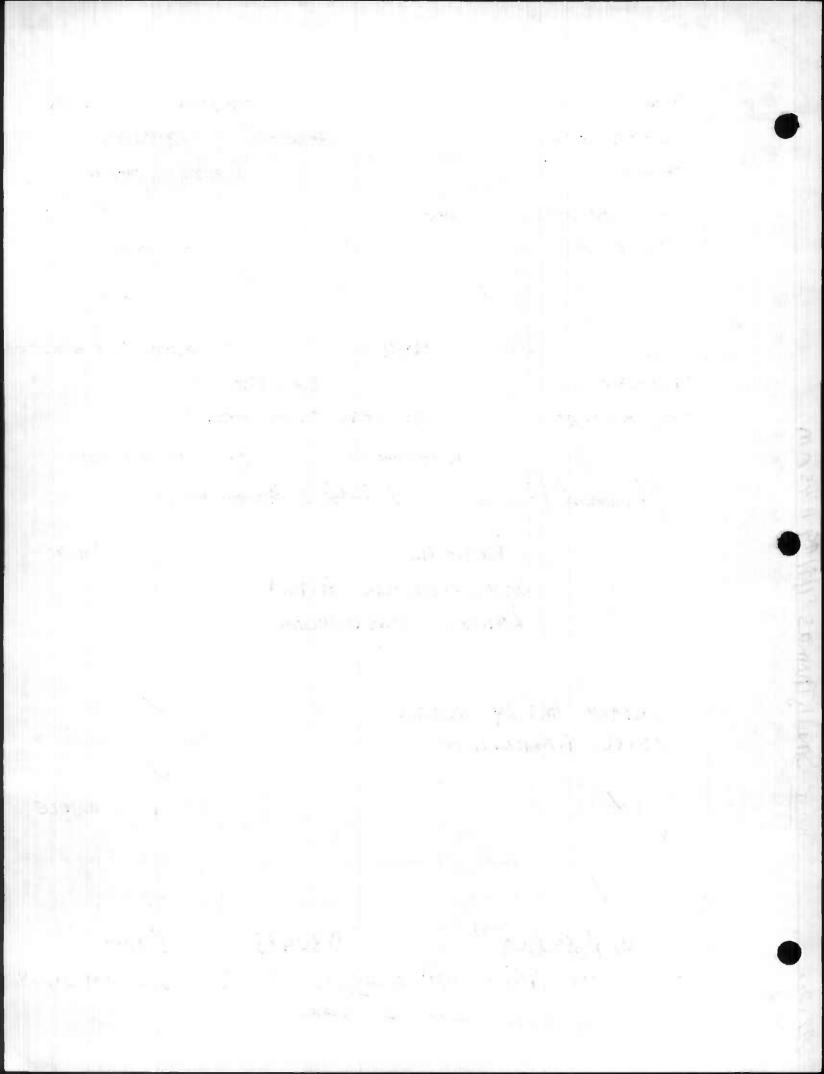
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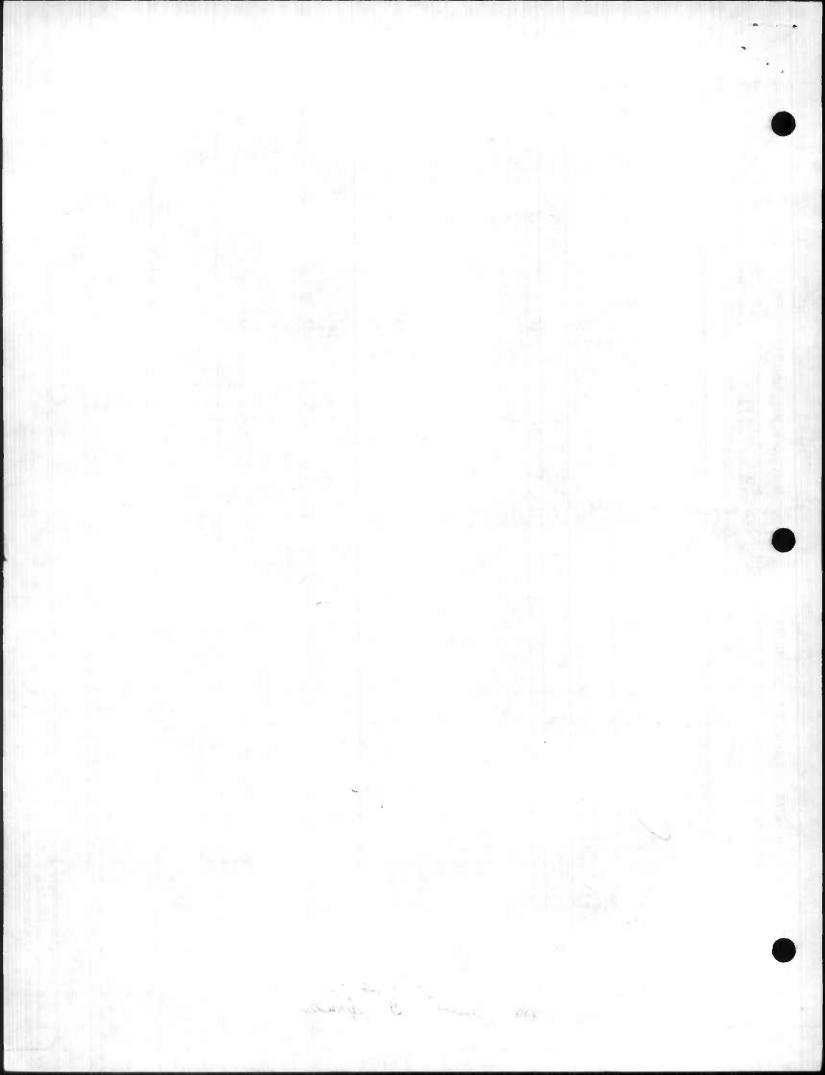


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State of Maryland / Department of Health and Mental Hygiene

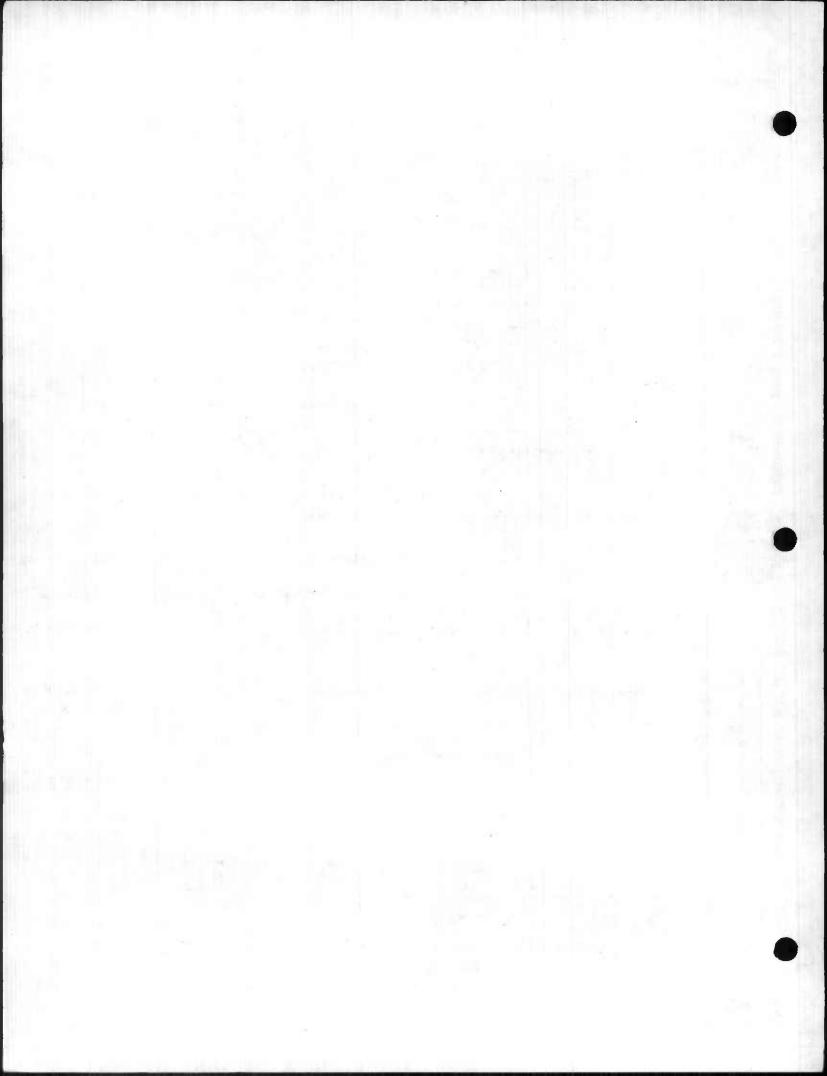
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D Hand	17. Father's Name (First, Middle, Last)		House Wile	18. Mother's Name	(First, Middle, M						
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Ball permit Depart Import any Ini	21. Signature of Funeral Service Uconsee 22. Name end Address of Facility Leonard J.Ruck Funeral Home Inc. 5305 Harford Rd, Baltimore, Md 21214										
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F 3 5 8		·cd		8358		July	8,1999				
	30 Name and eddress of person who cor						1				
State	Dr. Gracio Patric: 31. Date filed (Month, Day, Year)	32. Regisfrar's Signeture		ille, MD 2	21234						

BHB



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State Registrar

DHMH 16 Rev 6/95

Registrar

31. Date filed (Month, Day, Year)

32. Registrer's Signeture

and address of person who completed cause of death (Item 23a) (Type, Print)

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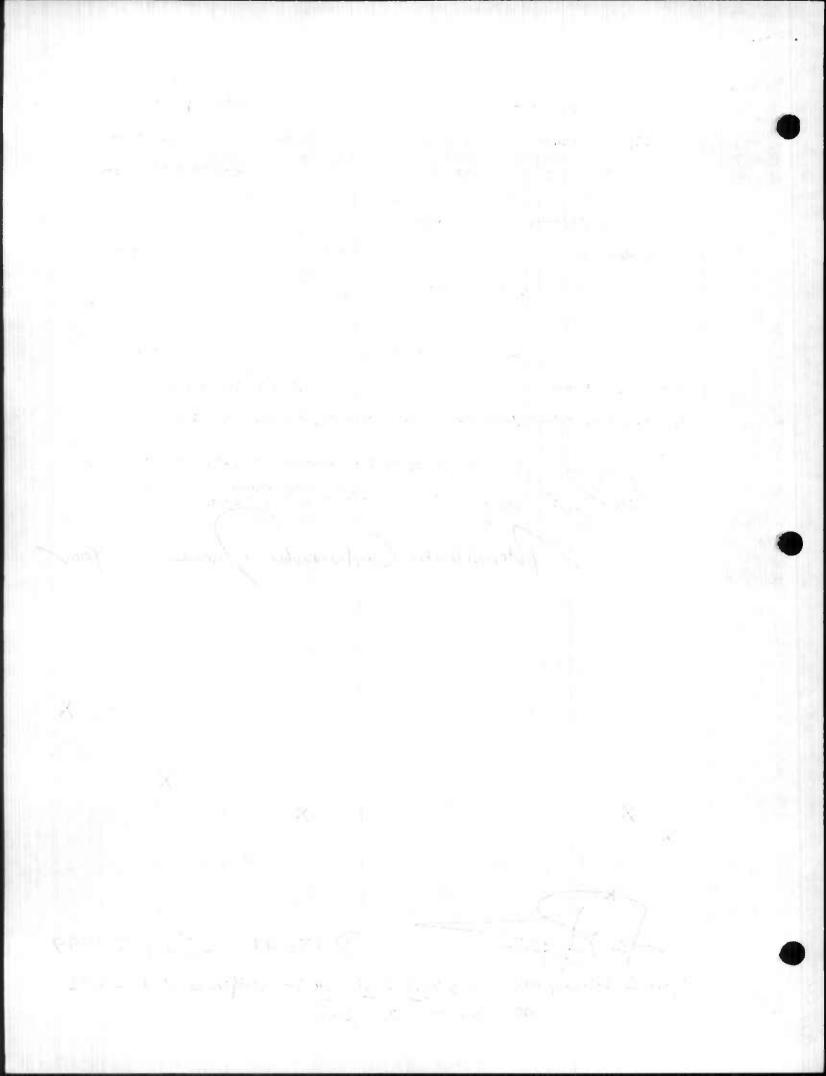
111 Penn Street, Baltimore, Maryland 21201

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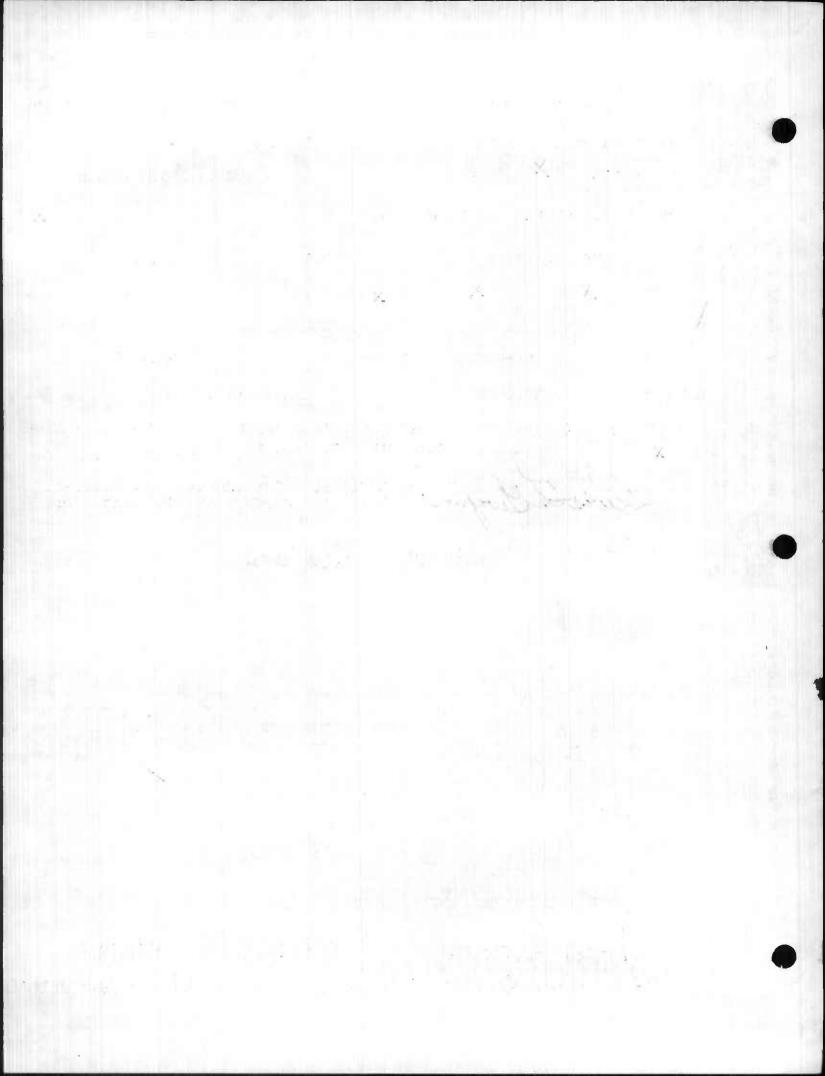
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To Street and Number 10.2 pc Code 10p. Citizen of What Country? 10.20 Hart Rd. 10.2						Cei	rtificate	of Death	R	leg. No.		1200
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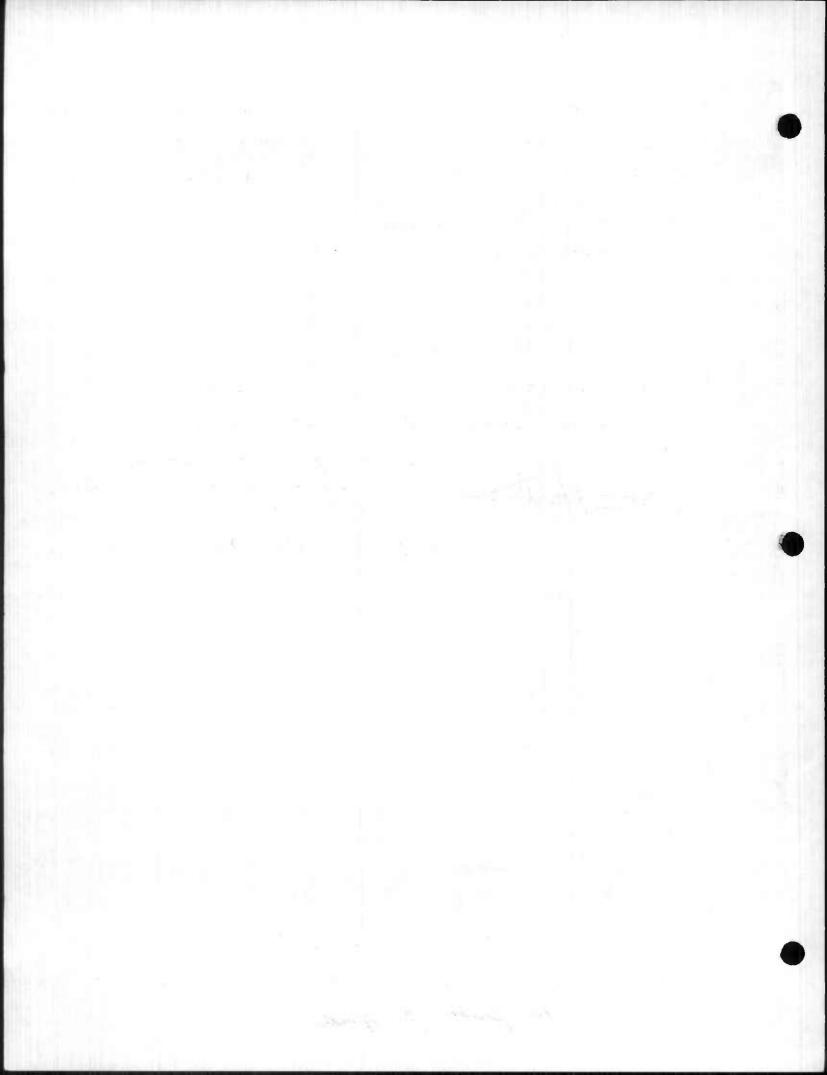
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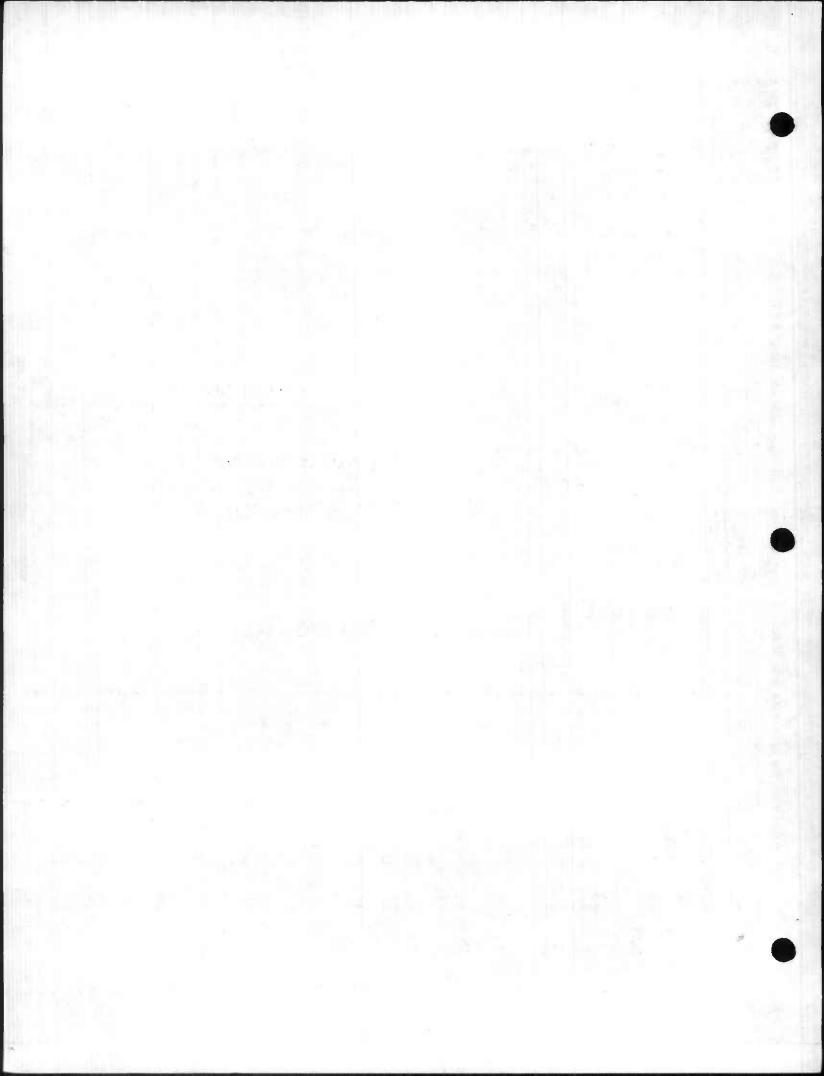
				Certificate o			g. No.	
Physic	ian	Decedent's Name (First, Middle, Last				Data of Deeth Month	h Day Yeer	
/Medi		Frances Elizabet				July	6 1999	
Exami	ner	4a. Facility Name (If not institution, give			4b. City, Town, or Lo	ocation of Deeth	4c. County of Dea	ath
	,	4230 Littlestown P		William A.W.	Westminst		Carroll	
Funeral Director		5. Social Security Number 6. Social Security Number 1	ex 7. Age (In yrs.	lest birthday) If Under 1 Yas Yrs. Months Day		8. Data of Birth (Month, Dey,	Yeer) 9. Bii	rthplaca (Stete or For country)
		Usual Residence of Decedent	70			December 2	22, 1925 M	aryland
8 ₩		10a. State 10b. County	10c. Cit	y, Town or Locetion				10d. Inside City Lin
al', or items 23a or 28a-f show Exprimer must be notified at	Funeral Director	MD Carrol	l Wes	stminster				1 ☐ Yes 2 💢
or 28	ie l	10e. Street end Number	1).1	10f. Zip Code	1	10	0g. Citizen of Whet C	ountry?
23a	a	4230 Littlesto	wn Pike	2:	1158		USA	
- E	Jue	11. Marital Status	12. Was Decedent Ever in U, Armed Forcas?	S. 13. Was Decedent o	f Hispenic Orlgin? (Spuben, Mexican, Puerto	ecify Yes or No-	14. Rece - Am Black, Whi	
2 0		1 Never Married 2 Married	1 Yes 2 No	1 ☐ Yes 2 ☐ N			Specify: Wh	
	d by	3Ã Widowad 4 □ Divorced	Yaer or Dates:					
iene. r than "natur the Medical	Completed	15. Dacedant's Ed (Specify only highast grad	de com <i>pleted)</i>	16a. Decedant's Usual Occ (Give kind of work dor	supation ne during most of work ired)	ing	16b. Kind of Business	s/Industry
Hygiene. ther than	d mc	Elementary/Secondary (0-12)	College (1-4or 5+)	Homemaker	100)		Own Home	
d other event,		17. Father's Name (First, Middle, Last)			18. Mothar's Nam			
200	To Be	Richard M. Merr	yman		Julia	A. Gali	lagak	
end Mer is marks aumatic		19a. tnforment's Neme/Ralationship (7		19b. Mailing Addrass (Stra				Zip Code)
ENB		Terry L. Turn	baugh - son	4230 Littlest	town Pike.	Westmins	ster. MD	21158
		20a. Method of Disposition	20b. P	tece of Disposition (Neme of ematery, cremetory or other p			20c. Location - City of	
nt: If its		1 Burial 2 □ Crametion 3 □ 4 □ Donation 5 □ Othar (Specify	Hamovai from Stale	adowridge Memo		7/9/99 E	lkridge,	MD
Department of important: If it any injury or once.		21. Signature of Funeral Service Licela		22. Nama and Add	dress of Fecility			
Depa impo		23a. Part. Enter the disease, or comp shock, or haart failure. List only of		Gary L. Kau	ifman Funeral	Home at M	eadowridge M MD 21075	lemorial Park
Medical xaminer		Immediate Cause (Finat	1 1 10 // /4					3 4 4
xanımer	Į.	disease or condition resulting in deeth)	0.	math 1 d	Many	hill's	C	10 NR
	xaminer	resulting in deeth)	Dua to (o		(ASM)	hllis	C	NONE
	al Examiner	resulting in deeth) Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Dua to (o	r as a consequence of):	(ATRI)	hllis	C	NONE
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24 hours effer deeth. Funeral Director: After this certificate has been signed by the attending physician end stelly filled in by the funeral director, page 2 should be deteched for use as the buriel-transit	To Be Completed by Physician/Medical	Part tt. Other significant conditions could be a cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Lasf 25. Was cesa rafarrad to medical axaminer? 1 Yes 2 No 27. Mannar of Death 1 Naturat 5 Panding investigation 3 Suicide 4 Homicida 29a. Certifier (Check only 2 Medical Exam	Due to (or Due to (or	r as a consequence of): r as a consequence of): r as a consequence of): ulting In the underlying cause ER/Outpatient 3 DOA 28b. Time of Injury M 1 ome, ferm, street, factory, office of and/or invastigation, in my	givan In Pert I. 26. Placa of Daat Dther: 4 Nursing Ho jury at fork? Yes 2 No se tima, data and placa, y opinion, daath occurs	23b. Did tol 1 Ye 24e. Was ar perform 1 Ye 28d. Check only one 28d. Describe ho 28f. Location (Str City or Town, and dua to the ca red al tha tima, da	n autopsy 24b. n autopsy 24b.	Probably 4 Unkr Ware eutopsy findinavailable prior to completion of cause of daath? 1 Yes 2 No Paral Route Number, Paral Route Number, Paral Route Number, Paral Route Number, Paral Route Number, Paral Route Number, Paral Route Number, Paral Route Number, Paral Route Number, Paral Route Number,
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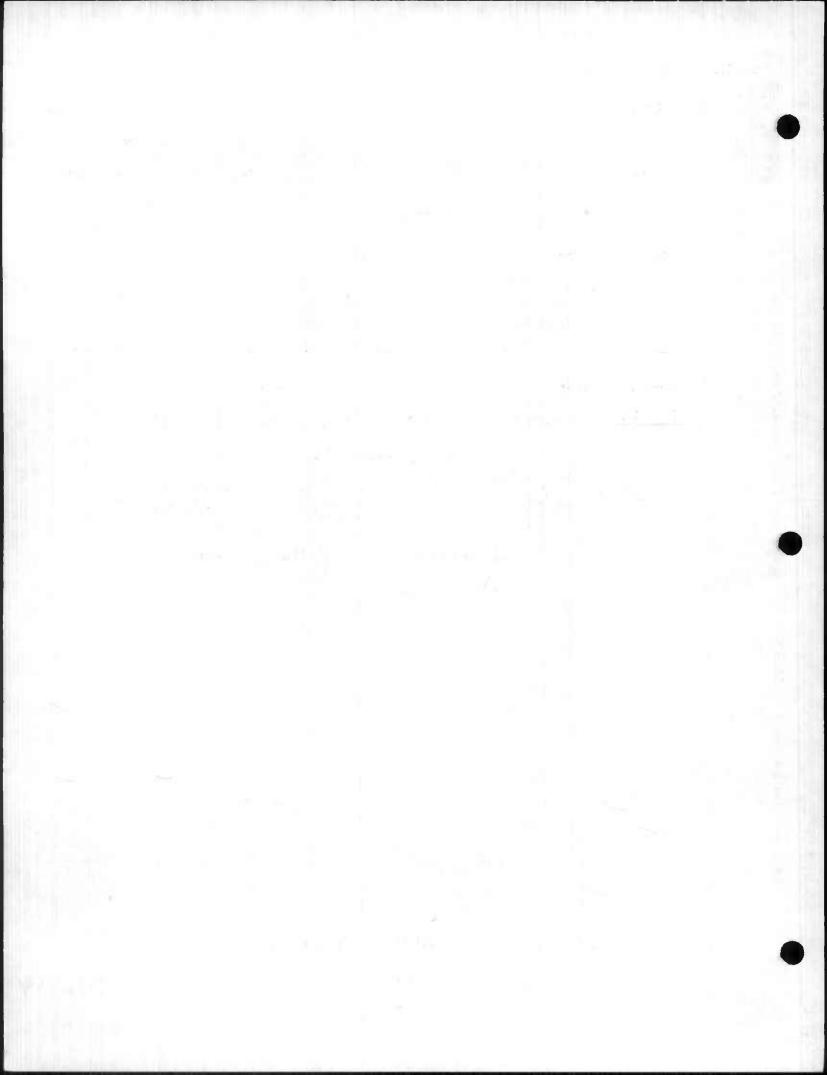
			•	Cei	rtificate	of E	eath			Reg. No.	0.0	- 6.	200
1. Decedent's Name (First	t, Middle, Lasi	1)		1					2. Date of Do				ms of Death
an SANTINA	TUMM:	INELLO							JULY	8,	1999		85 P.M.
4s Facility Name (If not in	stitution, give	street and nu	mber)			4b	. City, To	wn, or Lo	cation of Deat		County of De	esth	
3005 RUECK	ERT AV	ENUE					BAL	TIMO	RE CIT	Y	N.	/A	
5. Social Security Number			7. Age (In yrs. I		ff Under 1 Months	Year Deys	If Under		8. Date of Bi (Month, D.	rth	9.8		itate or Foreign
216-28-4567 Usual Residence of Deced		□ M 2KC)KF	75	Yrs.	W.O.M.I.O	Doyo	1,0010		9/24		ı	MARYLA	ND
10a. State 10b. 0	County		10c. City	, Town or Lo	cation							tOd. insi	ide City Limits
MD 1	BALTIM	ORE	I	UTHER	VILLE							1□	Yes 2 No
MD 10e. Street and Numbar					10f. Zip C	ode	-			10g. Cit	izen of What (Country?	
	RT PLAC	CE			21	093				113	SA		
1406 NEWPO		12. Was Dec	edent Ever in U.	S. 13. \			panic Ori	gin? (Spe	city Yes or N Rican, etc.)		14. Rece - Ar		en,
	Married	1 Tes	2 XNo	1				, rueito i	noari, etc.)		Black, WI	nite, etc.	
3 🖫 Widowed 4 🗆 Di	ivorced	If Yes, Gr Yeer or D	etes:		1□Yes 2	MIAO	Specily.				Specify:	WHITE	3
15. De	ecedent's Edu highest gred	cation		16a. Deced	ient's Usual kind of work	Occupat	tion	of working	10	16b. K	ind of Busines	ss/Industry	
15. De (Specify only Elementary/Secondary (12TH GRADE		College (1-4or 5+)	life. I	DO NOT use	retired)	ming mose	Di WOINII	·y				
12TH GRADE				HON	MEMAKE	R				O	NN HOME	E	
17. Father's Name (First, A	Middla, Last)						18. Motha	r's Name	(First, Middle	, Maiden	Sumeme)		
VINCENT P	APA						CON	CETT	A BARR	ANCO			
19a. Informant's Name/Re	elationship (T)	ype, Print)							l Routa Numl	er, City o	r Town, State	i, Zip Code)	
JOANNE FETZI	ER-ZOU	R D	AUGHTER		5 NEWP		PLAC	E L	UTHERV	ILLE	, MD ?	21093	
20a. Method of Disposition 1 ☑ Buriel 2 ☐ Crem		Bamayal from	06	ace of Dispo	sition (Name netory or oth	of er plece)		Data	20c. Lo	ocation - City	or Town, Sta	ite
4 Donation 5 Of				RDENS	OF FA	ITH	CEME	TERY	7/12	PA	RKVILLE	E, MD	
21. Signature of Funeral S	Service Licens	100		22	. Name and	Address	of Facilit	у					
1//				TH	HE JOH	NSON	FUN	ERAL	HOME,	P.A.			
23a. Part1. Enter the dise shock, or heart failure	ase, or compl	lications that o	aused the deeth	. Do not ent	er the mode	CH F of dying	, such as	BLV cardiac o	r raspiratory	WSON arrast,	MD ?	21286 Appro	ximata
shock, or heart failure	e. List only o	ne cause on e	each line.									HILLOLA	al Between and Deeth
fmmediate Cause (Finel		1		/								-	
disease or condition resulting in death)	1	a	-Ung (anco								10	
Sequentially list conditions if any, leading to immedial cause. Enter Underlying					luence or):							1	
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Pert II. Other significant c	onditions cor	ntributina to d	eath but not resu	Iting in the ur	nderlying cau	usa dive	n in Part f		23b. Did	tobacco	use contribe	uts to the ca	nuse of death
Å.									18	Yes 2	□No 3□	Probably	4 Unknov
3										an autor	osy 24	b. Were sut	opsy findings
									pen	omeur			n of cause
									10	Yes 2	DNo.	1 ☐ Yes	2□ No
25. Was case raferred to n	medical					-	26 Place	of Dooth	(Check only		3110	10100	2010
	The state of the s	Hospital:	Inpatient 2 1	ER/Outpatien	it 3 DOA	Othe				D	AUGHTE 8 MOther (S	R'S R	ESIDEN
-		28a. Date		28b. Tima of				-	ne o∟ nes 28d. Describe			респу)	
1-2 Natural 5	Pending investigation	(Mon	th, Day Year)	Injury	М	c. Injury Work	as 2 🗆 I						
3 ☐ Suicide 6 ☐	Could not be detarmined	28e. Place	of Injury - At ho	me farm str	eet factory				28f. Location	(Street er	nd Number or	Rural Route	Number.
4 Homicide	Gotammod	buildi	ng, etc. (Specify)	,				City or To				
	ertifying Phys	sician: To the	best of my know	vledga, daath	occurred at	tha tima	a, data an	d place, a	and due to the	cause(s	and manner	as stated.	
29a. Certifier 12 Co (Check only 2 Me	edical Exami	ner: On the b	asis of examinati ner stated.	ion and/or inv	restigation, i	n my opi	nion, daa	th occurre	ed at tha tima	, date and	I place, and d	dua to the ca	use(s)
29b. Signeture and title of	certifier				29c.	License	numbar			29d. Da	te signed (Mo	onth, Day, Y	ear)
Line	Inter	Lus	no		T	14:	317	2		T	1.1. 9	,199	19
30. Nama and address of p	person who co	omplated caus	a of death (Item	23a) (Tune		-				UV	7	1	
/ Te :	Hr - 5	- OA	9517	La -	ford	R	1 1	in los	hore,	Mn	21-	24	
31. Date filed (Month, Dey,	Year	30 0	legistrar's Signat	ura	10.00	/			ince,	10	216	_37	
		6											
101 13 19	99	Meren	19.	100	outs!								
	/												



State of Maryland / Department of Health and Mental Hygiene

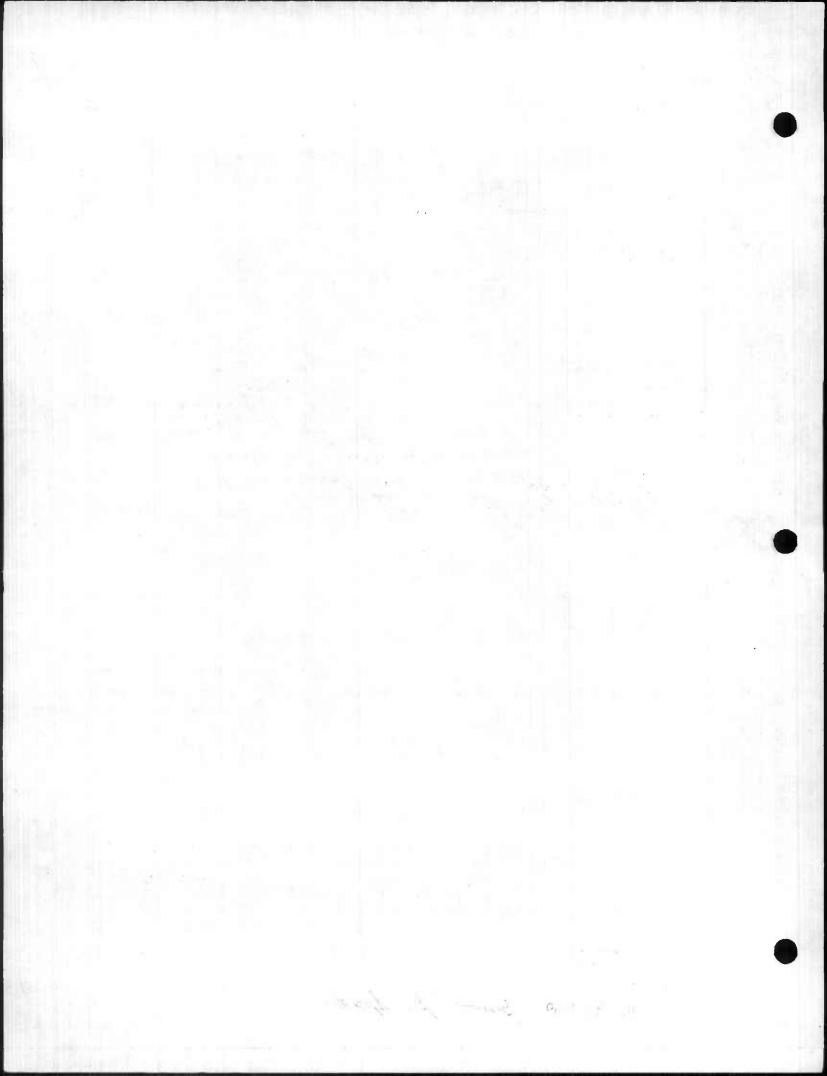
AMEND ITEM#3,15&19a G773 7-20-99 J.A. Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Deeth 3. Tima of Death **Physician** Month Year PM 10 Gene Thacker July Leonard 9:45am 1999 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Baltimore 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day) Birthplaca (State or Foraign Country)
 New York 5. Social Sacurity Number **Funeral** 1 € M 2 □ F 48 Yrs. New Director 220-54-7651 Usuel Rasidance of Dacedan the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show is marked other than "natural", or items 23s or 28s-f shov irsumatic event, the Moulcal Examiner must be notified at Md. N/A Baltimore 1 Yas 2 No Directo 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 238 5206 Nuth Avenue 21206 USA permit. Pages 1 and 2 should be filed within 72 hours efter death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examines must anges. Funerai 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Naver Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Spacify: Specify: White by 3 Widowad 4 Divorced Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businaas/Industry Elamentary/Sacondary (0-12) Collaga (1-4or 5+) Electronics Technician Steel Production 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) James H. Thacker Aida Diaz 10 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Thomasina Thacker-Wife 5206 Nuth Ave. Baltimore, Md. 21206 20b. Place of Disposition (Nama of cematary, crematory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Ststa 1 ☐ Burial 2 Cramation 3 ☐ Ramoval from Stata Hilltop Service Corp. 7-13-99 Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Saprice Licansae Michael E. Canapp 22. Name and Addrass of Facility Leonard J. Ruck Funeral Home Inc. 5305 Harford Rd. Baltimore, Md. 21214 23a. Part1. Enter the disease, or compilcations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset end Death **Physician** /Medical tmmediata Causa (Final live Carrinoma he disaasa or condition rasulting in daath) **Examiner** Dua to (or as a consaquance of): Examiner that the death certificate be executed physiclen end s the buriel-trans Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Causa (Disaasa or Injury thet initiated avants rasulting in death) Last Dua to (or as a consequence of): Box 68760, Physician/Medical Due to (or es e consaquanca of) 88 use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? the signed by the 1 Yes 2 No 3 Probably 4 Onknown þ 24b. Wara autopsy findings availabla prior to completion of cause of daath? should l 24a. Was an autopsy performed? Completed page 2 s 1 Yas Division of Vital or Attanding Physician: Be 25. Was casa rafarred to medical axaminar? 26. Placa of Daath (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No Certification: To 1 Inpatiant 2 ER/Outpatiant 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Beath 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? 5 Panding Invastigation After 1 Natural thin 24 hours efter death.

the Funeral Director: A mpletely filled in by the ft death. 1 TYas 2 No 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homicida 29a. Cartifian Medical 1 🖰 Certifying Physician: To tha bast of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signatura end titla of cartifia MID D 31464 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) 821 N Enlaw Fr Sonte 308 Bult. MD 144214211 WD State Registrar



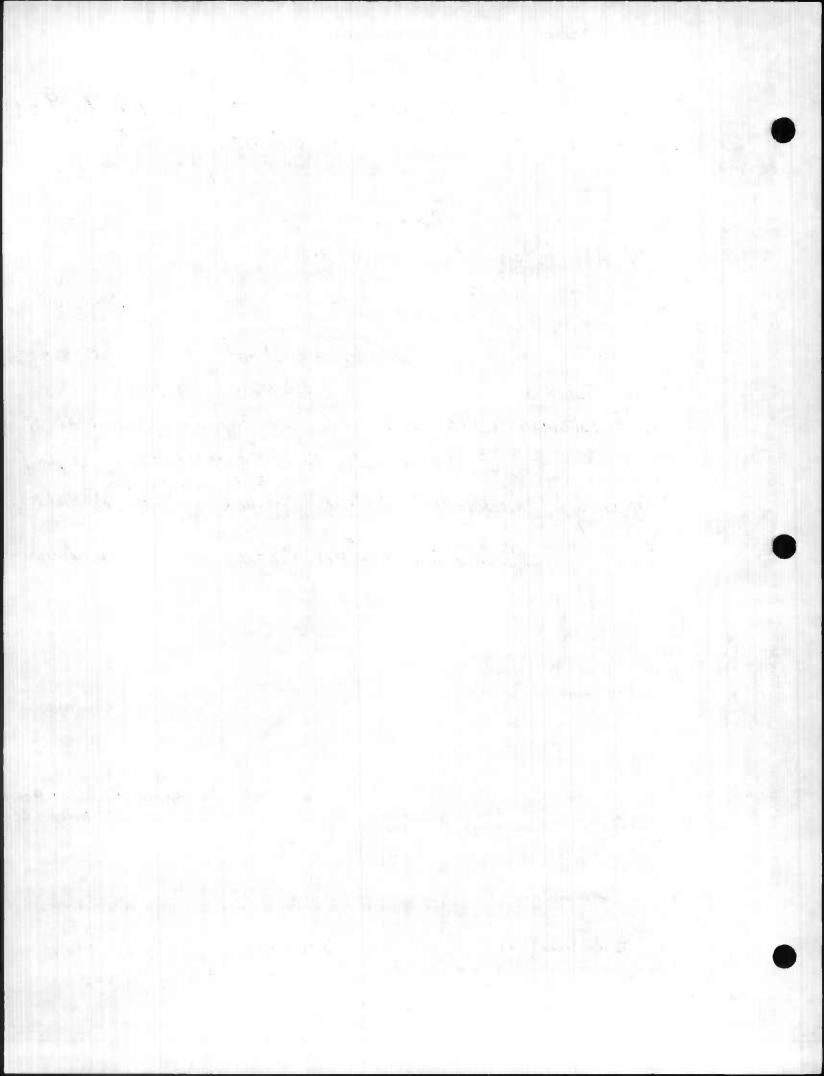
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Replace men Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** 9 1999 RONALD VEROVSKY 12:30 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2408 CRESTKNOLL RD. REISTERSTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Dele of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Hours Months 1G-M 2□ F Yrs. 213-76-5317 41 Director MARYLAND 1958 Usual Residence of Decedent the Maryland 10s Stete 10b County 10c. City, Town or Location 10d Inside City Limits BALTIMORE REISTERSTOWN 1 Yes 2 No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 na 23a or munt be 21136 2408 CRESTKNOLL RD. USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Bleck, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Merried 1 Yes 2 No 21215-0020 Specify Specity: WHITE à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) DIRECTOR OF OPERATIONS ROADNET Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental VEROVSKY BLANCHE YANKELOFF **ABRAHAM** 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a If hem 27 is or other tra ILENE VEROVSKY(WIFE) 2408 CRESTKNOLL RD. REISTERSTOWN, MD 20a. Method of Disposition 20b. Place of Disposition (Neme of cametery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State Department of important: If any injury or CHEVRA AHAVAS CHESED 7/11/99 RANDALLSTOWN, MD 4 Donation 5. Other (Specify) 21. Sign of unerel Service Licenses 22 Name and Address of Facility BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 replications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, one cause on each line. Part1. Enter the disease, or complications, or heart feilure. List only one Approximate Interval Between Onsel and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) HANGING Examiner Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical Due to (or es a consequence of): 88 980 Por signed by the a Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ YUnknown Records, à 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was an eutopsy performed? Completed page 2 certificata has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director. Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1X Yes 2 No this funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of tnjury 26a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 1 Natural 5 Pending 1 Yes 2X No 24 hours after death.

Funeral Director: A investigation 12:30A 2 Accident 3 ☐ Suicide 7/9/99 AUTO-EROTIC ASPHYXIATION 6 Coutd not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) REISTERSTOWN, MD 2408 CRESTKNOLL RD 21136 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide AT HOME IN BASEMENT Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred ei the time, date and place, end due to the cause(s) and menner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 5 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of purson who completed cause of death (Item 23a) (Type, Print) III Penn St. Dixon, 31. Date filed (Mont State Registrar



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Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene #29D #25 PER MD G773 7-13-99 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Vaar Month **Physician** 1999 Theodore Wilson 18 9:00 am May /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner 3404 Elgin Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 58 Vrs Director 218-60-7960 July 29, 1940 unknown Usual Residence of Decedan 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limita 1 X Yes 2 □ No Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be r 3404 Elgin Avenue 21216 unknown Funeral 12. Wes Decedent Ever in U,S. Armed Forces? unknown 1 ☐ Yes 2 ☐ No If Yas, Giva 14. Race - American Indien, Black, White, etc. 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: black à If Yas, Giva Year or Detes: 3 ☐ Widowed 4 ☐ Divorced unknown Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Fathar's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Maidan Sumame) nit. Pages 1 and 2 should be artmant of Health and Mental ortant. If Nem 27 is marked or unknown unknown 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) unknown 20b. Place of Disposition (Name of cemetary, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donation 5 🖾 Other (Specify) in state 21. Signeture of Fur eral Service License 22. Name and Address of Facility Director Ronald S State Anatomy Board, 655 W. Baltimore Street nec Baltimore, MD 21201

23e Part1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiretory errest, shock, or haart failura. List only ona cause on each line. Approximate Interval Batween Onset and Death Physician Immediate Causa (Final disease or condition resulting in death) /Medical Examiner Physician/Medicai Examiner exten attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es e consequence of): resulting in death) Last signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, py 24b. Wara autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? Completed page 2 s cartificata has 1□Yaa 2₽No 1 Yas 2 No 25. Was casa referred to medicel examiner? Be 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Pesidance 6 Other (Specify) 1 Yas 2 No 10 After this 28a. Data of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Devatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Mospital c within 24 hours at To the Funeral C completaty filled 1 Certifying Physician: To the best of my knowledga, daeth occurred at the lima, data and pleca, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

P31464

6-28-99

N. Enton St 308, Balt. m1) 2/201

State Registra

31. Date filed (Month, Day, Year)

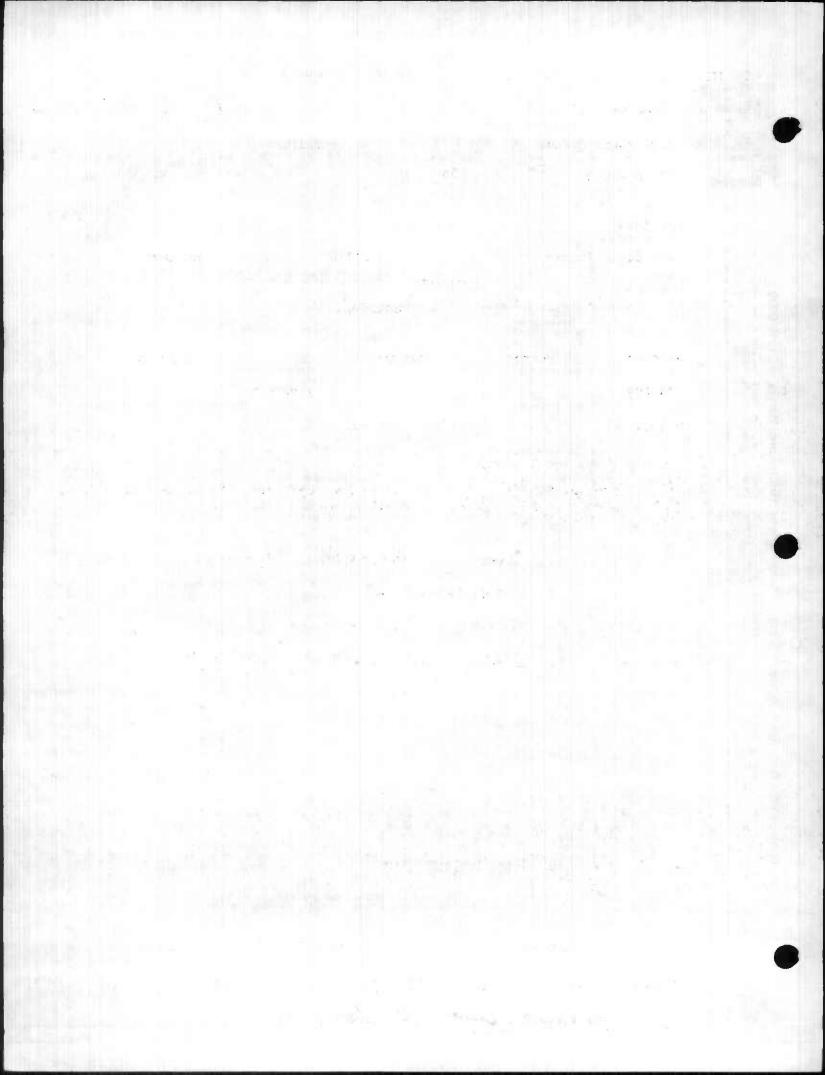
30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

JUL 1 3 1999

HAYS HOMI

32. Registrar's Signatura

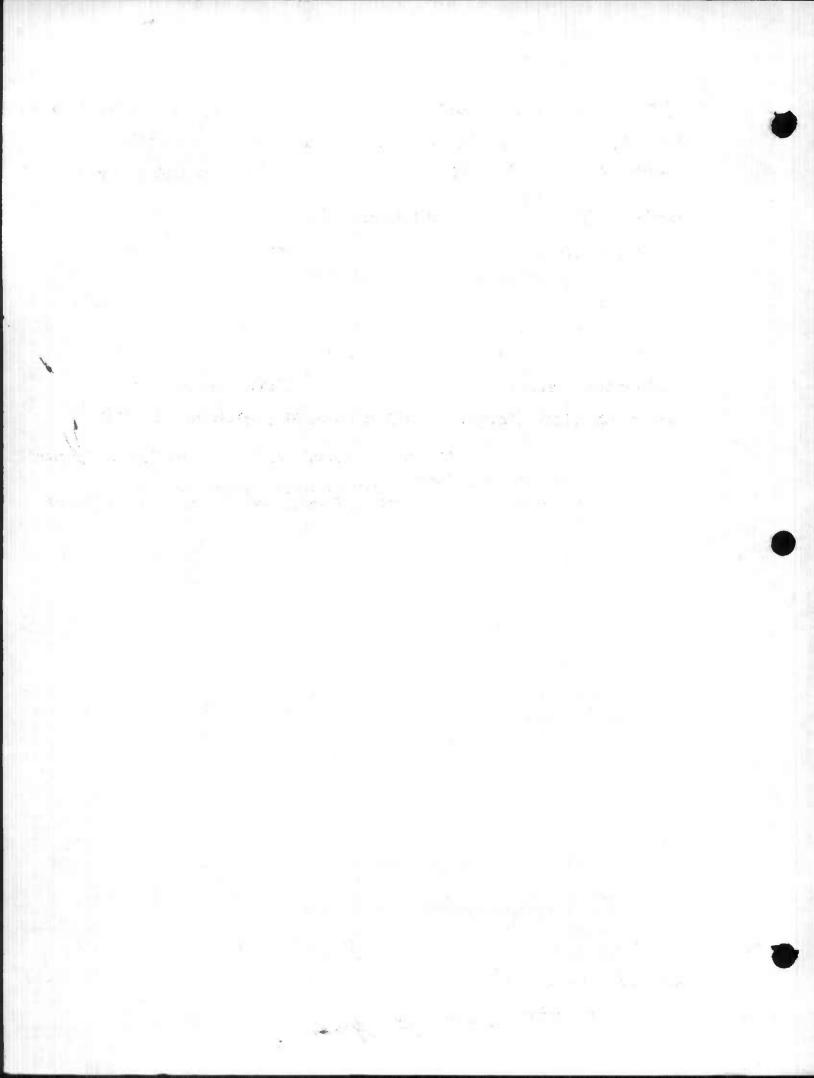
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State of Maryland / Department of Health and Mental Hygiene

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020	within 72 hours after ene. than "natural", or its na Medical Externing	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Datas:		1.0	□Yes 2X01	No	Specify:				Specify:	W	hite	
5-0	72 ho	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a.	Decede	nt's Usuei Oc ind of work do O NOT use re	ccup	ation during most d	of working		16b. Kin	d of Bus	iness/Ind	ustry	
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<u>lan</u>	Mentel Mentel of arkad of attic ava	To Be	John Joseph We	igman							May					
Baltimore, Maryland 21215-0020	ges 1 and 2 should be filed within 72 hours after deeth with the Merylan tof Heelth and Mentel Hygiene. If item 27 is marked other than "natural", or itams 23s or 28s-f show or other traumatic avant, the Medical Experient must be retified as		19e. informent's Neme/Reletionship (7		19b.		Address (Str									
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Ba	Depa Impo any Ir		1	Kevin E	. ECKer	Mc	Cully-	Pc	lynia	k Fun	eral	Home,	P.	A.	25 405	
	С		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	licetions thet caused	the death. Do n	ot enter	7 E. P	dyin	g, such as c	AVE.	, Ball espiratory	to.,	Md.	212	Approximate	ta
s	Physician		Snock, or neart failure. List only o	ona cause on each iir	10.									į	Intarval Beh Onsat and I	
P	/Medical Examiner		fmmediete Ceuse (Finai disaase or condition	· Cirr	hosis	5									lyr	
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oʻ	an and		Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying	_	Ovival	oused'n	ence or:	+	inn] [10 y	Irs
68760,	ing physician and as the buriel-fransit	edical	cause. Enter Undarlying Ceuse (Disease or injury thet initiated events resulting in deeth) Last		Due to (or es a c	onseque	ance of):	-	COVI							
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	")		30. Name and eddress of person who che Robin McKenz		oath (Itam 23a) (520	0	East	ern	AUR	Bal	timo	ove,1	MD 21	1224
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Certification: To ne Hospital or Attand n.24 hours after death ne Funeral Director: / 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical To the Hosp within 24 ho To the Fune completely fi (Check only

e us

29c. License number 29d. Date signed (Month, Day, Year) 0005 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) B=170. 21202

State Registrar

DHMH 16 Rev 6/95

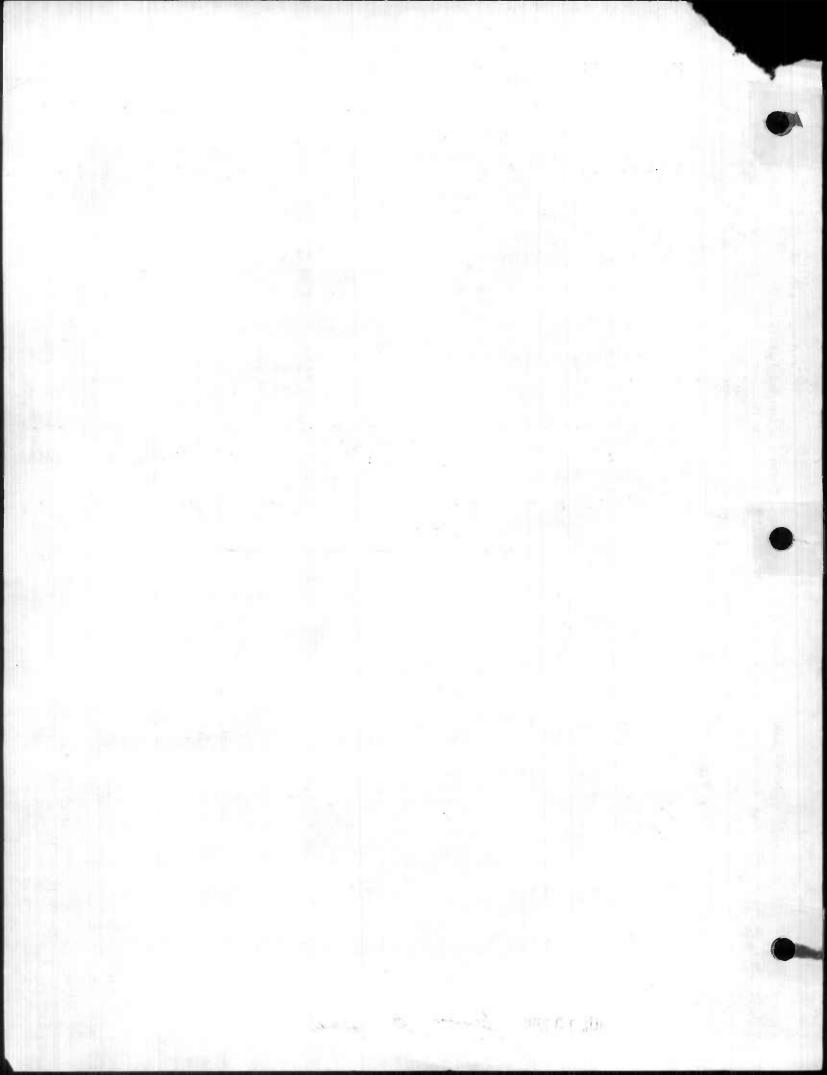
29b. Signeture and title of cartifier

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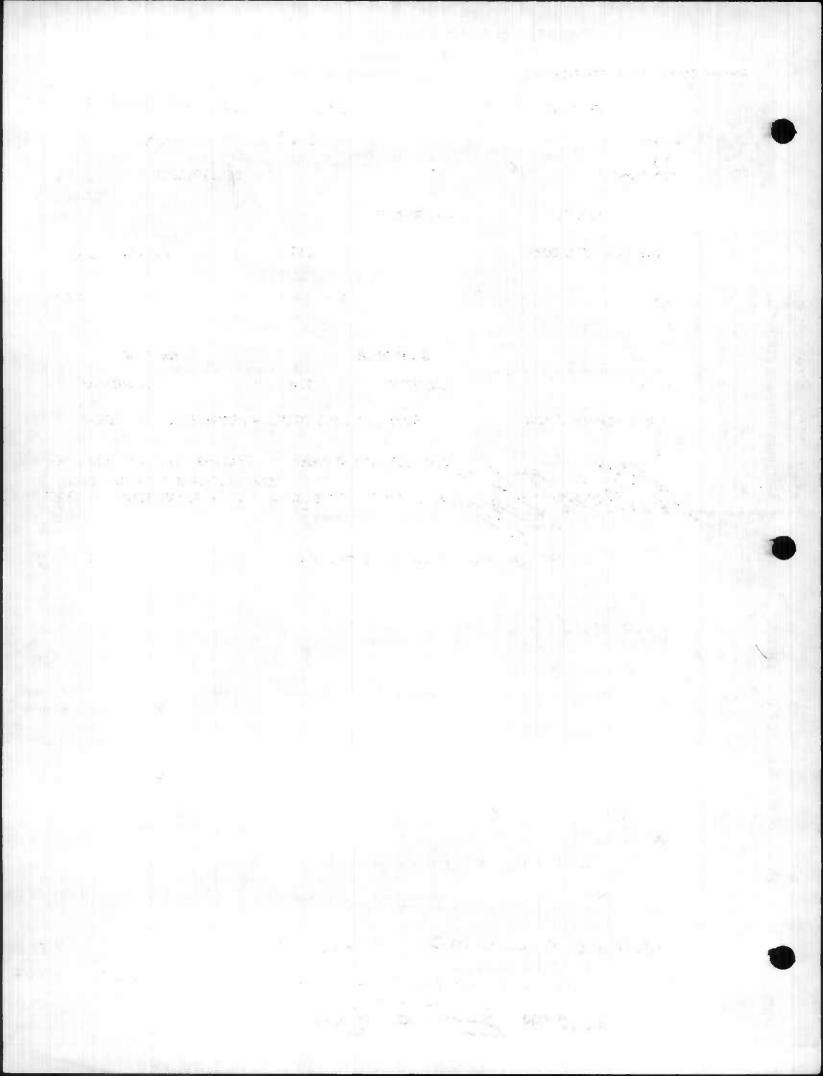
32. Registrer's Signeture

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	1. Decedent's Nam		13/99 EW e, Last)		08	rtificate of	Dodin	2. Date of De			3. Time of Death
hysician		BLANC				WIENE	R.	Month July	Day 19	Year	5:10 AM
edical miner	4e Facility Name (I	If not Institution	n, give street and nu	mber)			4b. City, Town, or	Location of Deat	h 4c. County	of Death	
1	5. Sociel Security N		6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Deys			N/A	9. Birthp	place (State or Foreigntry)
	206 -03-8	739	1□M 200F	7	9 Yrs.	Months Days	PIOUIS MIII	DEC.18	,1919	COU	PA
tor	10a. State MD	10b. County		1	y, Town or Lo				7	1	10d. Inside City Limit 1 ☐ Yes 2 X N
al Director	10e. Street end Nu		DRIVE	L		10f. Zip Code	21784		10g. Citizen of V U.S.		ntry?
by Funeral	11. Marital Status 1 □ Never Marr	_	led 1 ☐ Yes	ve		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🎇 No		Specify Yes or No rto Rican, etc.)	Specify	k, White,	can Indian, elc. WHITE
Completed	(Special Special cify only highe	t's Education st grade completed) College ((Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	orking	16b. Kind of Bu		dustry	
0000	17. Father's Name	(First, Middle,	Last)		HOMEM	AKEK	18. Mother's Na	me (First, Middle	, Maiden Suman		
10 8	LOUIS			LE	VINSON		IDA			LVERN	
	19e. Informant's No				6109	OAK HILI					
	20a. Method of Disp 1 Donation	Cremation	3 □Removal from		emetery, cre	osition (Name of matory or other ple		Date 7/11/99	20c. Location -		
	21. Signification	Moral Southco	Licografia	100		2. Neme end Addre					
10	23a. Parti. Enter t shock, or hea	he disease, or in failure. List	complications that	ed the death	h. Do not en	ler the mode of dy	ing, such as cardia	ac or respiratory a	arrest,	1	Approximate Interval Between
	Immediate Ceuse	(Final	0								Onsel and Death
r	disease or condition resulting in death)	n	a. He		ag I Conse	Stro	KR				1 009
edicai Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	enditions, nmediate	b	Due to (o	r es a conse	quence of):				1	
	Cause (Disease or that Initiated events resulting in death)	5	c	Due to (o	r as a conse	quenca of):					
Physiclan/M	Part II. Other signif	licant condition	ons contributing to d	eath but not res	ulting in the u	inderlying cause gi	iven In Part I.	23b. Did	tobacco use co	ntribute t	o the causa of deat
Phys								10	Yes 2 No	3 Pro	bably 4 Unkno
Completed by								24e. Was	s en autopsy ormed?	av cc	Vere autopsy findings vailable prior to completion of cause i death?
Com								10	Yes 2 No	1	□Yes 2□No
Be	25. Was case refer examiner?		Hoonital:	4		O	thor:	eath (Check only			
7: To	1 ☐ Yes 2 27. Menner of Deel		1/4	Inpatient 2 of Injury oth, Day Year)	ER/Outpalie 28b. Time of	III 30 DOA	4 🗆 Norsing	T	how Injury occur		ify)
atlor	1 Natural 2 Accident	5 Pendir investi	getion	nth, Day Year)	Injury		ork7]Yes 2 ☐ No				
ertific	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could determ	sined 288. Piece	a of Injury - At he ing, etc. (Specif	ome, farm, st	reet, factory, office			(Street and Numb own, State)	per or Rur	ral Route Number,
edical Certification:	29e. Certifier (Check only one)	Certifyir 2 Medicat	ng Physician: To the Examinar: On the b and man	best of my kno easis of examina ener stated.	wledge, deal lion and/or in	h occurred et the tovestigation, in my	ime, dele end plac opinion, death occ	ce, and due to the curred at the time	cause(s) and m	enner es s and due l	stated. to the cause(s)
Me	29b. Signature end		B,000	, MI			se number		29d. Date signed		Day, Year)
	30. Name end addr	ress of person	who completed cau	se of deeth (lien	23a) (Type	Print)	Road				andziza
State	31. Date filed (Mon	th, Day, Year)		Registrer's Signs		-			/		
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of Maryland / Department of Health and Mer	ntal Hygiene 🧐 🦠	21964
Certificate of Death	Reg. No.	

2. Date of Death

3. Time of Death

	1. Decedent's Nam	a (First, Middla, Last)
Physician /Medical	Charles	I. Wallace
Examiner	4a. Facility Name (If not institution, giva s
Examino	C+ A	a Haandaa'

Funeral

Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nature!, or Items 23e or 28a-f show any Injury or other traumetic event, the Medical Examiner must be neitled at once.

Baltimore, Maryland 21215-0020

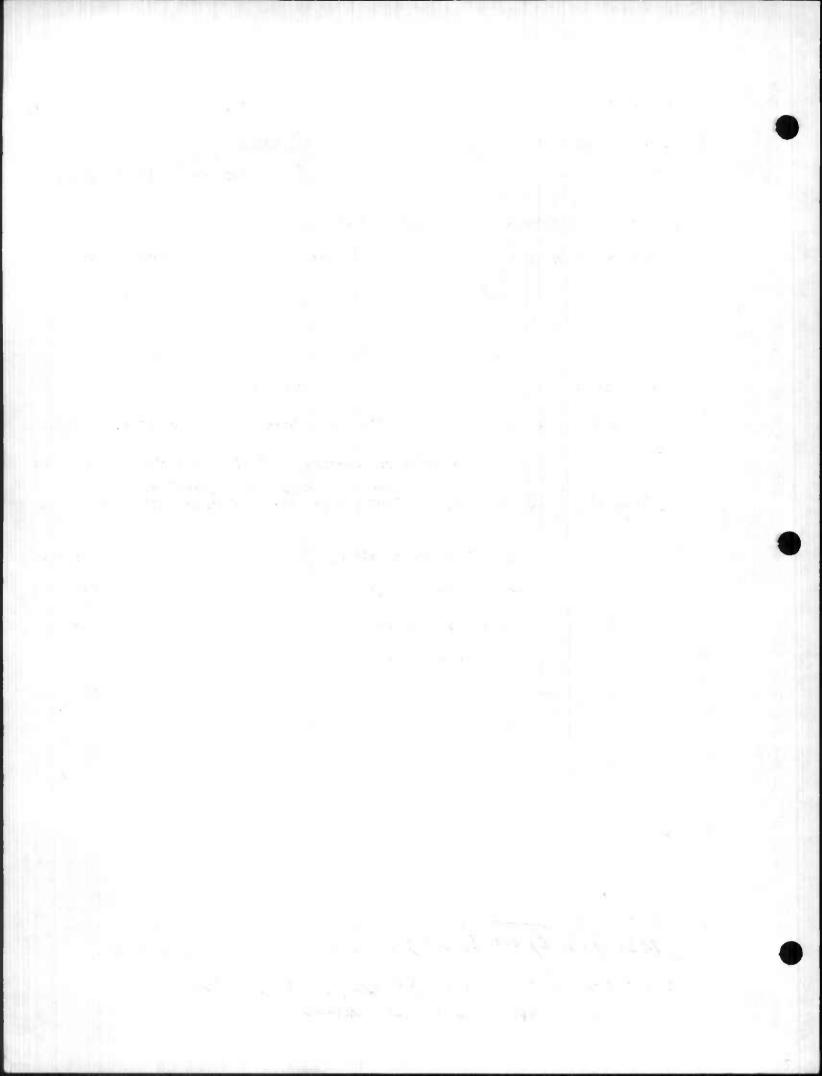
Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be associted within ZA hours after death.

To the Funeral Director: After this certificate has been signed by the attanding physician and completaly filled in by the funeral director, page 2 should be detached for use as the burla-transit Division of Vital Records, P.O. Box 68760,

		1. Maile	ace, Sr.				,		July 9	, 1999		11:20a
er			iva street and numbe	r)					Location of Deat	h 4c. Cou	nty of Death	100
	St. Agne					W11 1 4 3		Baltimo	- mpr		N/A	
	5. Social Security N 218-10-8	3782	Sex 7. A	Aga (In yrs. le 82	est birthday) Yrs.	Months Da		Under 24 Hrs lours Min.	(Month, Da	v. Year)	9. Birth Cou 917 M a	placa (Stata or Foreig intry) aryland
-	Usual Residence of 10a. State	10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
000	Maryland	Bal	ltimore		Cato	nsville						1 ☐ Yes 2 N No
	10e. Street and Nur				0400	10f. Zlp Coo				10g. Citizan	of What Cou	intry?
	719 Maide	n Choice	e Lane			21	228			Un	ited S	States
	11. Marital Status1 ☐ Naver Marri3 ☒ Widowed	ed 2 Married	If Yes, Give	37] No	I	Vas Decedant Yes, specify (Cuban, M	nic Origin? (S fexican, Pueri pecify:	pecify Yes or No to Rican, etc.)		Raca - Amar Black, White city: Whit	, etc.
		15. Decedent's I		:		lent's Usual Oc			These states	16b. Kind o	f Business/Ir	ndustry
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П	Giles L.	2-433	í				18.		me (First, Middle	, Meigen Sun	ieme)	
ŀ	19a. Informant's Ne		-		19b. Mellin	a Address (Str	reet end		Laird ure/ Route Numb	er. City or To	wn. Stete. Zi	in Code)
	James M.		/ Son			01d Tu						MD 21037
	20a. Method of Disp	position		0.0	ece of Dispos	sition (Neme one tory or other	f		Date		on - City or T	
		☐ Cremation 3 5 ☐ Other (Spec	☐Removal from State city)	0		er Ceme		, 7	//13/99	Westmi	nster	Maryland
	21. Signatura of Fu	neral Service Lica	ansae		22	. Name and Ad	dress of	Facility				ilar y rana
	Man	. 0 10	· Mian	•					nc. Fun			
	23a. Pert1. Enter the shock, or hear	le disease, or con it failure. List ont	mplications that cause y one cause on each	ed the death line.		305 Har er the mode of				ore, Mi	0 2121	Approximate Interval Batween Onset and Death
	Immediate Ceuse (disease or conditio		Conge	stive	Heart	Failur	6					10 Years
	resulting in death)		a. Jonge		as a conseq							10 lears
		_	Gastr	ointes	tinal	Bleedi	na				1	Week
l	Sequentially list con if any, leading to Im	nditions,	0		as a conseq		- J					
1	Ceuse (Disease or	rlying Injury	_{c.} Respi	ratory	Failu	ure						2 Days
	that initieted events rasulting in death) l			•	as a consequ	,					1	
			d. Atria	1 Fibr	ilatio	on		_				
	Pert II. Othar signifi	cant conditiona	contributing to death	but not resul	lting in the ur	derlying cause	e given In	Pert I.	23b. Did	tobacco use	contribute	to the cause of death
	•		,			,,	9,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1	Yes 2□N	o 3 Pro	obably 4 XUnknov
•												
	· · ·		752						24a. Wes	en eutopsy ormed?	a	Vere autopsy findings vailable prior to ompletion of ceusa I death?
									1 🗆	Yes 2 N	0 1	☐ Yas 2 No
	25. Wes case reference axaminer?	red to medical				1		. Place of De	ath (Check only	one)		
	1 ☐ Yas 🔏		Hospital: 1 X Inpa	tient 2 🗆 E	R/Outpatien	t 3□ DOA	Other:	4 ☐ Nursing H	lome 5 ☐ Ras			lty)
	27. Manner of Deetl 1X Natural 2 □ Accident	5 Pending investigation		jury Jay Year)	28b. Time of Injury		Injury et Work? 1 ☐ Yes	2 🗆 No	28d. Describe	how injury oc	curred	
	3 ☐ Sulcide 4 ☐ Homlcide	6 Could not determined	28e. Placa of Inbuilding, e	njury - At hor etc. (Specify)	me, farm, stre	eet, factory, off	ica		28f. Location City or To	(Street and Nu wn, Stete)	imber or Ru	ral Route Number,
	29e. Certifier (Check only		hysician: To the bes miner: On the basis and manner s	of examinet								
	290. Syrapor and	title of Legitier .	y an	h s	ni).		706	mber		29d. Date sig	ned (Month	
1	30. Name and eddre	ess of person who	ompleted cause of	death (Item	23a) (Type, I		, 50			outy.	, 13	
	IVAN AK	SENTIJE	ICH	900 Ca	ton Av	venue	Balt	imore.	Maryla	nd		
	31. Date filed (Mont		32. Regis	ar's Signati			all					
		JUL 1	3 1999	: Eper	- 10	· pp	The same					

Registrar **DHMH 16 Rev 6/95**



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Daath 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 5:15 AM 1999 JULY 4e Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth GIEN BURNIE ARUNDEL HOSPITAL YORTH COUNT If Undar 24 Hrs. 7. Age (In yrs. last birthday) If Undar 1 Yaar 5. Sociel Security Number 8. Data of Birth Month, Day. 9. Birthplaca (Stata or Foreign Months Deys 1 M 2 VF Hours 212-26-589 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Insida City Limits ANNE 1 Yas 2 No Alunde IMORE 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? MORE KOAD 12. Was Decedant Evar in U,S. Armed Forces? 1 | Yas 2 | ONO 1618 21144 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Bleck, Whita, etc. 1 ☐ Naver Married 2 ☐ Married 1 Yes 2 No Specify: IAC 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decadant's Education (Specify only highast grada complated) OF DED+. Elemantary/Secondary (0-12) Coltega (1-4or 5+) EAM STRESS ARMY 18, Mothar's Nema (First, Middla, Maidan Surname) 17. Fathar's Nama (First, Middla, Last) IOWAR ANCHE 9 DEWEL 199. Informant's Name/Ralationship (Type, Print) DAUSHER 19b. Malling Addrass (Straat and Number or Rural Routa Numbar, City or Town, Stata, Zip Code) 1902 ARMOR SEVERN, M.D ATRICIA 20b. Place of Disposition (Nama of cemetary, crametory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State July 1 Surial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) St CEMETERY 9,1999 HARMANS 21 Signature of Funeral Service Licenses 22. Nama and Addrass of Facility NuHER+ Sons FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliura. List only one cause on each line. Balto, M.D. 21216 Approximete Intervat Batween Onset and Deeth hour Immediate Ceuse (Finel diseasa or condition rasulting in daeth) 10 C ar Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consaquanca of): Dua to (or as a consequanca ot): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the causs of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 DINO 1 ☐ Yes 2 ☐ No 25. Was case ratarrad to medical 26. Placa of Death (Check only one) Hospital: 1 | Inpatient Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 2 No 2 ER/Outpatient 3 DOA 1 Yas 27. Manner of Death 28e. Deta of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascriba how injury occurred 28b. Tima ot 1 Natural 5 Panding Investigation Injury 1 Yas 2 Accident 3 Suicida 6 Could not be detarmined 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 - Homicida

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: **Physician**

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

7 is marked other than "naturel", or flams 23a or 28a-f shor traumstic event, the Modical Examinat must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or herr any injury or other trauments.

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DHMH 16 Rev 6/95

State Registrar

31. Data tited (Month, Day, Yaar)

JUL 1 3 1999

en

30. Nama and addrass of person who completed ceuse of deeth (Item 23e) (Type, Print)

Markan

1600 32, Registrar's Signature

- M.D

crain

1 Cartifying Physician: To the best of my knowledge, daath occurred et the time, date end placa, end dua to the cause(s) and menner as stated.

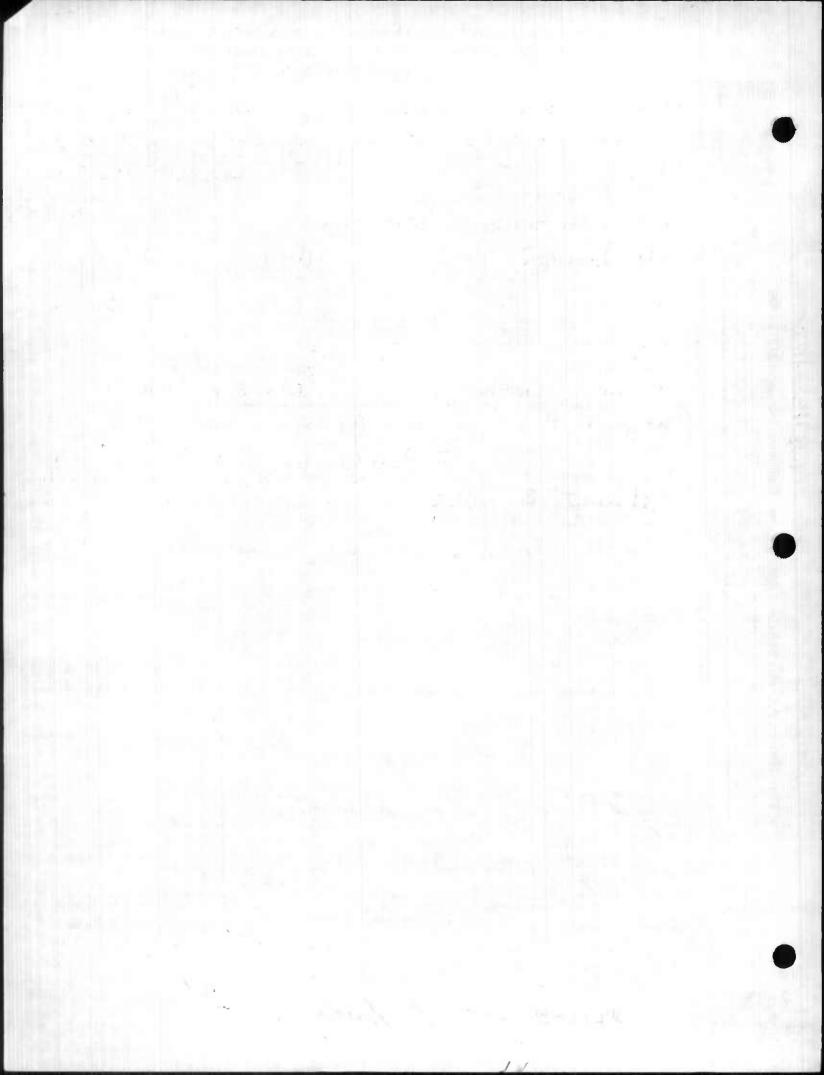
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete and place, end due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

21061

#602, Glen survice



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month July 1959 4c. County of Death

1. Decedent's Name (First, Middle, Last) **Physician** FRANK W. WHEATLEY /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) **Examiner** UNION MEMORIAL HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/30/1909 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 1 M 2□ F 89 Yrs. 218-01-1430 Director Uauel Residence of Decedent the Manyland 10a Stete 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic avant, the Medical Examiner must be notified at Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3203 N. CHARLES ST. APT. 21218 USA 301 Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Heelth and Mental Hygiena.
Int: if Item 27 is marked other than "natural", or ites 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Merried 25 Married Baltimore, Maryland 21215-0020 1 Yes 25 No Specify: Specify: WHITE g 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) SOCIAL SECURITY Elementary/Secondary (0-12) 12YRS College (1-4or 5+) ADMINISTRATION CLERK 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) AGNES HARRY WHEATLEY 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) HELEN WHEATLEY (WIFE) 3203 N. CHARLES ST. APT. 301 BALTO., MD21218 other 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burlal 2 Cremetion 3 Removel from Stete injury or Department if important: if any injury or GREEN MOUNT CREMATORY 07/10/99 BALTO., MD. 4 □ Donation 5 □ Other (Specify) 21 Signature of Funeral Service Licenses 22. Name end Address of Facility HENRY W. JENKINS & SONS C 4905 YORK RD. BALTO., MD. SONS CO 21212. 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, auch as cardiac or respiretory arrest, abock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical A cute Renel Examiner Due to (or es a consequence of): Examiner Frank Wilson Wheatley Hyperholenia buriel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): and Hypertension Physician/Medical Due to (or as a consequence of): the Digbetes use

3 DAYS YEARS YEARS

3. Time of Death

9. Birthplece (State or Foreign

10d. Inaide City Limits

Approximate Interval Between Onset and Death

DAYS

1€Yes 2 No

MARYLAND

7:14 0.10.

Part II. Other significant conditions of	contributing to death but not re	sulting in the underly	ying cau	use given In Pert I.	23b. Did tobacco use co	ontributa to the cause of death 3 ☐ Probably 4 Unknown
					24a. Was an autopsy performed?	24b. Were autopay findings available prior to completion of cause of death?
OS Mas and referred to medical						1 Yes 2 No
25. Wes case referred to medical examiner?					eath (Check only one)	
1 ☐ Yes 2 No	Hospital: 1 Denpatient 2	ER/Outpatient 3	□ DOA	Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	ner (Specify)
27. Menner of Deeth 1 ANatural 5 Pending 2 Accident investigation		28b. Time of Injury		c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occur	red
3 Suicide 6 Could not be determined		nome, farm, atreet, f	actory,	office	28f. Location (Street end Numb City or Town, State)	ber or Rural Route Number,

29a, Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, end due to the cause(s) and manner es atated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifing 29c. License number

1000 30. Name and address of per on who completed cause of death (Item 23a) (Type, Print) AT 2438 946 H13 July

Moranger HOSPITAL

7 N122

State Registrar 31. Date filed (Month, Day, Year)



DHMH 16 Rav 6/95

signed by t

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certificate director.

After this funeral

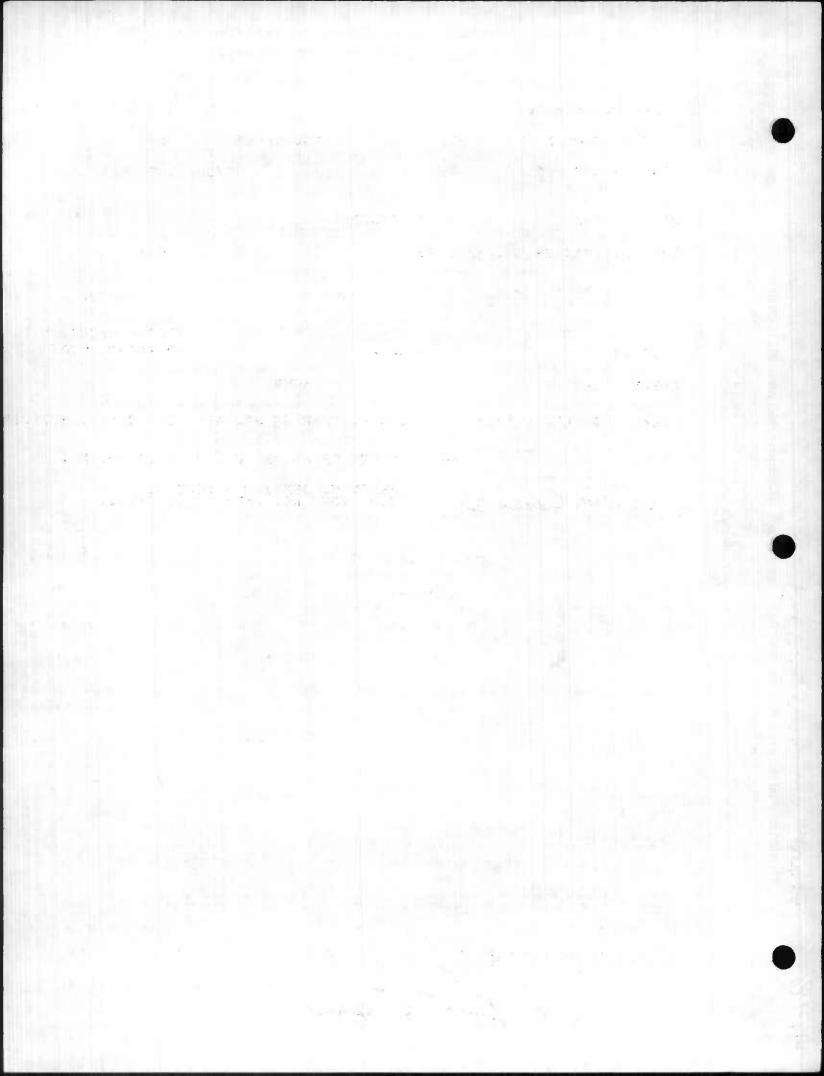
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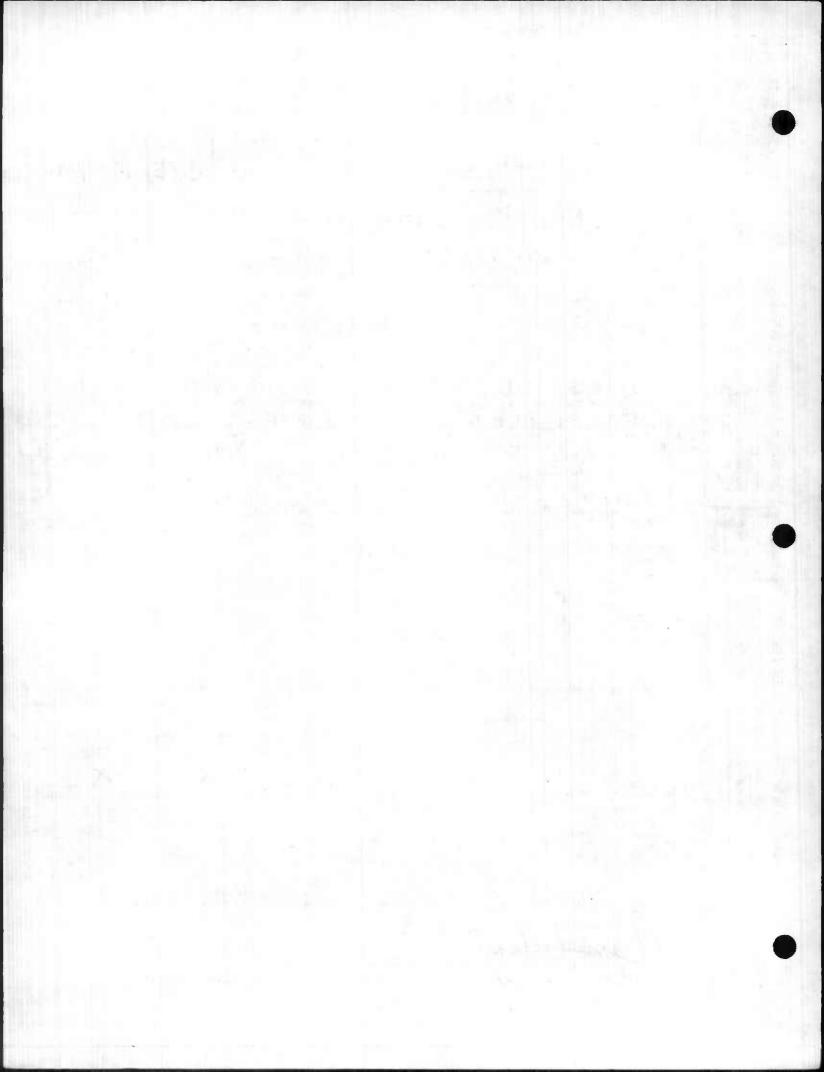
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State of Maryland / Department of Health and Mental Hygiene

-38	44-510			,	Certifica	te of Death	F	leg. No.	61	901			
	Physicia /Medic		1. Decedent's Neme (First, Middle, Le		rough		2. Date of Dea Month JULY	th Dey	Year	3. Time of Death			
	Examin		4e Facility Neme (If not institution, gi			r Location of Death	4c. County	9/A					
	Funeral Director			ET Sex 1X M 2 F 7. Age (In yrs	Yrs. If Under Months	BALT'IMO or 1 Year If Under 24 Hr Days Hours Mir	s. 8. Dete of Birth	37956	9. Bighplace Nobupty)	(State or Foreign			
Aaryland 21215-0020 2 should be filed within 72 hours after death with and Mental Hygiene.	the Maryland 28a-f ahow notified at	ctor	10a, Stete 10b. County				Inside City Limits						
	affer death with the Maryle or Name 23e or 28e-f aho oliner must be notified at	eral Director	10e. Street and Number ASh	land Au	le.	21205		Og. Citizen of V	SA				
	urs after af', or ha	by Funeral	11. Maritel Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Yeer or Detes:	If Yes, sp	edent of Hispanic Origin? (ecify Cuban, Mexican, Pue 200 No Specify:	rto Rican, etc.)		e - American ck, White, etc.				
	72	Completed	15. Decedent's E (Specify only highest gn Elementery/Secondary (0-12)		16a. Decedent's Us (Give kind of w life, DO NOT	uel Occupation ork done during most of w use retired)	orking	16b. Kind of B					
	al Hygien I other th	Be Con	17. Father's Name (First, Middle, Last) V 1	une	MPloye 18. Mother's No	eme (First, Middle,	Maiden Şumen	N/A				
	SPEE	To	19e. Informent's Neme/Reletionship (Type Print) (daught	19b. Mailing Address	ss (Street end Number or F	Gural Route Numbe	OSh I City or Town.	NO TO	(de)			
	of Health of Health I item 27 of other tr		MS, Lata Sha 20e. Method of Disposition 1 Burial 2 □ Cremetion 3 □		Plece of Disposition (No cerpetery, cremetory or		S ST.	Sa 17	City or Town,	,2/2/3 ,State			
	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other to once.		4 Donetion 5 Other (Special	(y)	22. Name e	ond Address of Facility	1/16/99	ans	dow	ne, Ma			
B	88188		23a. Pan I. Enter the bisease, or com	plications that caused the dea	th. Do not enter the mo	Ph L. Ku W. Nort de of dying, such es cardio	A Ave.	Palto est.	Ma	2/Z/6			
F	Physician /Medical		Immediete Cause (Finel		intoxicati					tervel Between nset and Deeth			
	Examiner	Jer	disease or condition resulting in death)	0.	or es e consequence of				1 1				
Division of Vital Records, P.O. Box 68760, or Attanding Physician: The law requires that the death certificate be executed after death.	cate be executed physician and sthe burial-transit	Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying	b									
	2 9 6	Medical	Cause (Disease or Injury thet initieted events resulting in deeth) Last	C Due to (or es a consequence of):									
	death cert a attandin d for use	Physician/M	Part II. Other algnificant conditions of	contributing to death but not re-	cause given in Pert I	23h. Did t	obacco usa co	ntribute to th	e cause of death?				
	mat me ed by th detache	by Phys					101	A.:	3 Probab				
	sw requir	Completed					24a. Wes a		availa	autopsy findings ble prior to letion of cause ath?			
	pag pag	Com					XY	es 2□No	PXY.	'es 2□ No			
	certificate irector, pag	o Be	25. Was case referred to medical examiner?	Hospitel:	ER/Outpatient 3□ 0	Other	seth (Check only of		(m. v.)	>= 00===			
	er this	-	17 No 2 No 27. Menner of Death	28e. Dete of Injury		ome 5 ☐ Residence XXOther (Specify) AT SCENT 28d. Describe how injury occurred							
	ath. Ar: After he fune	atlo	1 Neturel 5 Pending Investigation	1 2	Unknown								
DIV		Certification:	3 ☐ Suicide 6 ☑ Could not b 4 ☐ Homicide determined	28e. Plece of Injury - At h building, etc. (Speci Bldg.	City or Tow	281. Location (Street end Number or Rural Route Number, City or Town, State) 4 N. Exeter St., Baltimore, MI							
Di Hospital or	24 hou	Medical	1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated. **Common of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	within 2 To the	Me	29b. Signature and title of certifier		29d. Dete signed (Month, Dey, Year)								
			30 Name and address of person who	OCME	JULY 5, 1999								
			JAPEN LOC			et, Baltimor	e, Maryla	nd 2120)1				
	Stat	e	31. Dete filed (Month, Day, Year)	32 Registrer's Sign	eture /								

DHMH 16 Rev 6/95

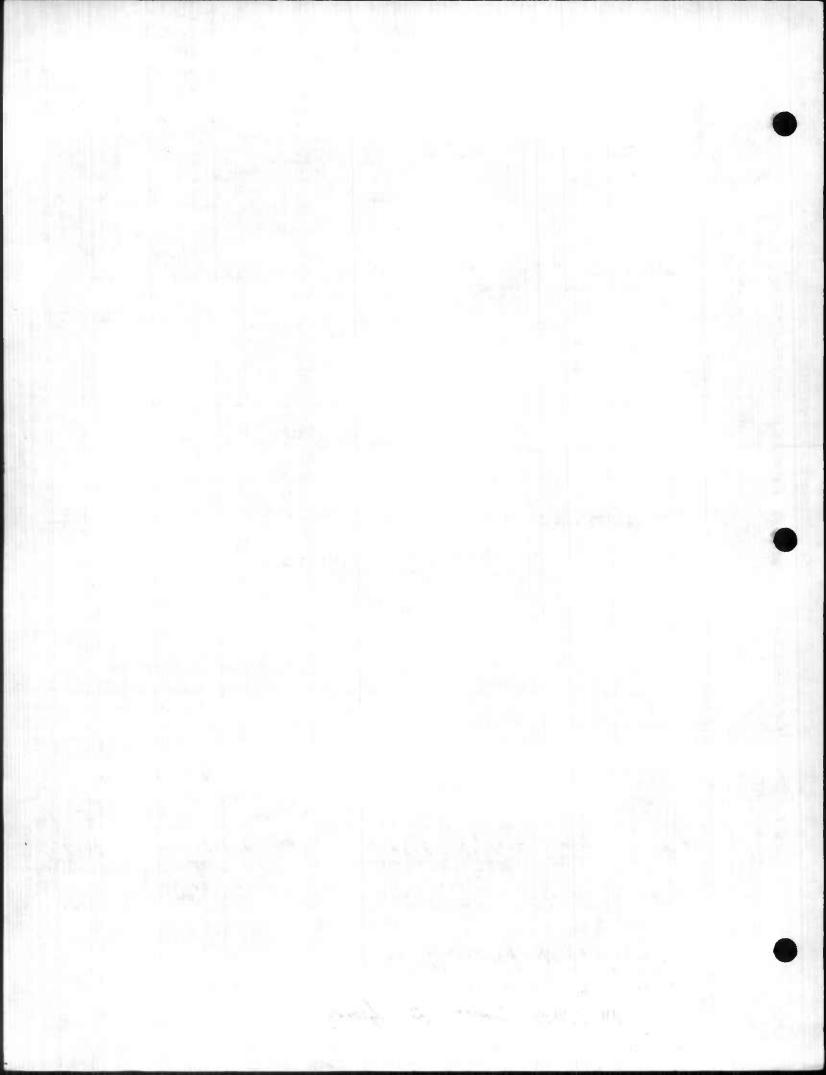
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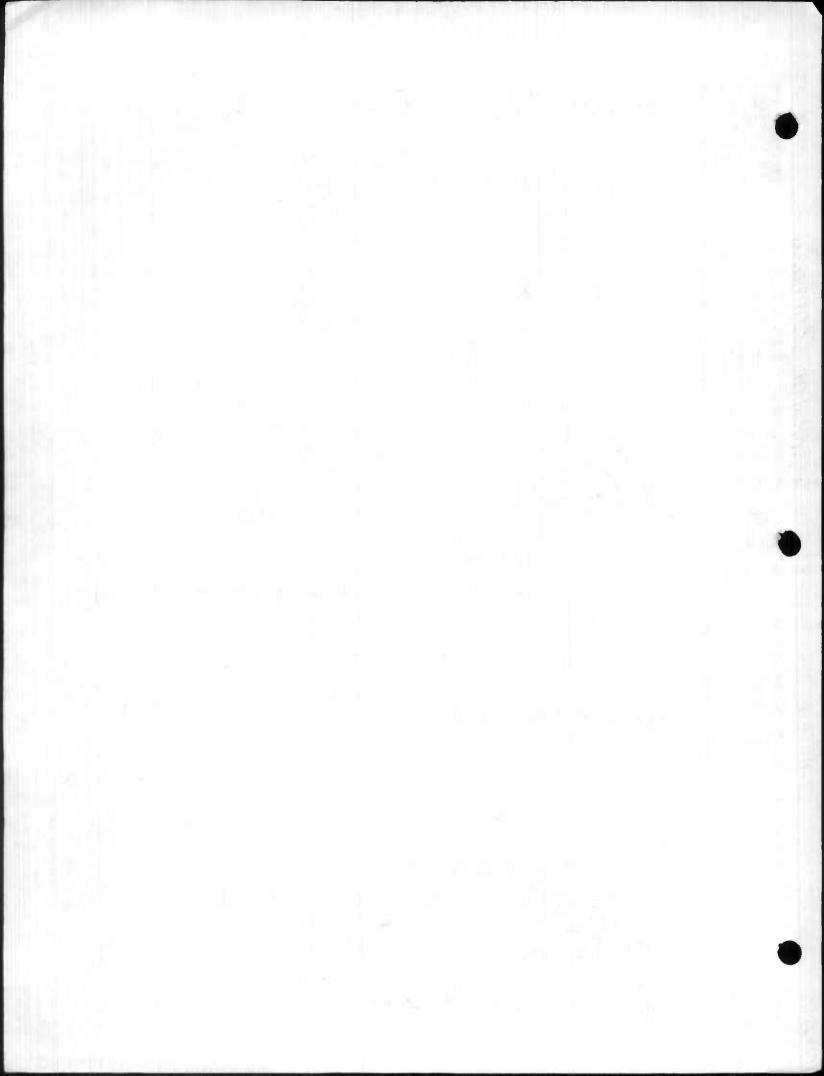
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State of Manyland / Department of Health and Mental Hygiene

_	. Decedent's Neme (First, Middle, Last)							2. Dete of De Month	eth Dey	Year 3.	Tima of Deeth	
n al	JASON S YEAKEL								03 199		2215	
	4s Facility Name (If not institution, g	rive street and nu	mber)			46	. City, Town, or Lo	Location of Death 4c. County of Death				
ı	MARYLAND ROUTE # 18 & DULIN CLARK RD. QUEE							WN	QUEEN ANNE			
	5. Social Security Number 6.	7. Age (In yrs	yrs. last birthday) If Under 1 Year If Under 24			If Under 24 Hrs. Hours Min.	8. Dete of Bird (Month, De	Birth 9. Birth		Stele or Foreig		
	005–76–5702 1 [™] X ^M 2□ F 19 Yrs. Months 1						TROUTS IMIT.				lvania	
Н	Usual Residence of Decedent		1.0			- 17				1.044		
ı	10a. State 10b. County		10c. C	ity, Town or Lo	cation						side City Limits	
Н	Delaware Kent	t	I	rederio	1						Yes 2 No	
	10e. Street and Number	10f. Zip 0	Zip Code			10g. Citizen of What Country?						
	22 Front Street		19946					USA				
	11. Meritel Stetus	edent Ever in t prces?	If Yes, specify Cuben, Mexic			panic Origin? (Sp , Mexican, Puerto	ecify Yes or No Rican, etc.)	No- 14. Rece - American Indien, Black, White, atc.				
	Never Married 2 Merried	If Yes, Gr	1 ☐ Yes 2♥ No If Yes, Give Year or Dates:			1 ☐ Yes 2√ No Specify:			Specify: White			
	3 Widowed 4 Divorced									WILLCE		
	15. Decedent's (Specify only highest g	Education trade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)				ing	16b. Kind of Business/Industry			
	Elementary/Secondary (0-12)	College (1-4or 5+)									
_	12 17. Father's Name (First, Middle, La:	O		Chem	ical	Mixe		a (Firet Middle	Indus Maiden Suma			
	Jeffrey R. Yeake	·						Nama (First, Middle, Maiden Sumame) e Ann Hayes				
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1	19e. Informent's Neme/Ralationship						nd Number or Rur				9)	
н	Julie Uriz (Moth	ner)	20h	Place of Dispos			et Frede	erica,D		19946 - City or Town, S	itata	
1	1 DBurial 2 Cremetion 3	☐Removel from	State	cemetary, crem	natory or oth	er plece						
	4 Donation 5 Other (Spec		Oc	dd Fello				7/9/99	Freder	ica,Dela	aware	
	21. Signature of Funerel Service Lic	ensee	//		Neme and				******			
	23a. Part1. Enter the disease, or co shock, or heert failure. List on	2 4/4	br	I I	MCCUII	Ly-Po	olyniak 1	uneral	Home P	.A.	230 roximata val Between	
TVELLIE C		b		or as a conseq						1		
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								10	Yea 22 No	3 Probably	4 Unknow	
									en eutopsy	24b. Were er	utopsy findings	
								performed? evailable complet			ion of cause	
								of death?				
_	ne Was seen mile and the mile of								Yes 2□ No	Yes	2 □ No	
	25. Wes casa referred to medical examinar?	Hospitel:		7		Othe	26. Place of Deet					
-	1 Yes 2 No 27, Manner of Deeth	28a. Date of Injury (Month, Day Year) DOA Curer: 4 Nursing H						ome 5 Rasi 28d. Dascribe			CENE	
1	1 □ Naturel 5 □ Pending	(Mon	th, Day Year)	Injury			oc 200 No					
	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify)									accide		
								281. Location (Street and Number or Rurel Route Number, City or Town, State) R+ 18, Queens tem				
Street Maryland												
29a. Certifilar (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar es stated. (Check only one) Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and mannar estated and mannar estated.												
on a tribution order of												
1	syo. Signature and title of certifier 29c. Licenso 0.C.						-1011-21211			L Date signed (Month, Day, Year) JLY 04, 1999		
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	sups	MV	Mo	111								
	30. Name end addrass of person who Stephen S.	o completed ceus		m 23a) (Type, I			Street,	D. 31.1		- 11.0	1201	



6			4 December Manager (Processor)			U	erunca	ile oi	Death		Reg. No.		
	Physici /Medic		1. Deceded's Neme (First, Middle, Last,	B.		Ź	ZAM			2. Dete of De Month	ob 1	Yeer 999	3. Time of Deat 2:40 pm
	Examin	er	4a. Fecility Name (If not institution, give					4	4b. City, Town, or L		h 4c. County		
	Europal	_	5. Social Security Number 6. Sec	County Gen		Spital . lest birthda	(V) If Und	er 1 Year	If Under 24 Hrs.	lumbia 8. Date of Bir	th		ward
	Funeral Director		212-28-3415	M 2□ F		73 Yrs.	Month	s Deys	Hours Min.	8. Date of Bir (Month, De Decem!	ber 9, 1925	Count	lace (State or Ford try) Virginia
and	1		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or	Location		•			10	Od. Inside City Lin
Mary	r 28a-f show	tor	Maryland Ho	ward				E	Ellicott City				1 ☐ Yes 2 🔀
\$ C	or 284	Oirec	10e. Street end Number				10f. Z	ip Code			10g. Citizen of V	What Coun	try?
St. wath w	ns 23a	ral	5450 Kerger Road		. =				21043			U.S.	
LUMZOU 1215-0020 within 72 hours after death with the Maryland	items iner m	Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 € Married	12. Was Deceder Armed Forces 1X Xes 2	3?		3. Was Dec	edent of H ecify Cuba	lispenic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	Blac	e - America ck, White, e	
21215-0020 d within 72 hours aff	Fram.	by	3 ☐ Widowed 4 ☐ Divorced	Yes, Give Year or Dates		1944 1946	1 Yes	2 No	Specify:		Specify	<i>'</i> :	White
3-0 Z	natur	eted	15. Decedent's Edu (Specify only highest grade	cation e com <i>pleted)</i>		16a. De	cedent's Us	ual Occup	etion during most of world)	king	16b. Kind of Bu		
12.	r than	ompi	Elementery/Secondary (0-12) UNK	College (1-40) UNK	r 5+)	life	. DO NOT		stal clerk			J. S. Po	st Office
		Se C	17. Father's Name (First, Middle, Last)						18. Mother's Nam	e (First, Middle	, Meiden Surnem	10)	
Kandolph Baltimore, Maryland	f Health end Mental Hygitem 27 is marked other other traumatic event,	To		nley Zamzov	N					lva	a Myrtle She	enk	
Mar Mar	7 is m traum		19a. Informant's Name/Relationship (Ty Ms. Pamela Zamzow	_		19b. Me	-		e <i>nd N</i> um <i>ber or R</i> ui Road Ellicott			Stete, Zip	Code)
re, N	item 27 other tr		20a. Method of Disposition		20b.	Plece of Dis	sposition (N	eme of		Date Date	20c. Location -	City or Tox	wn, State
I Dom	nt: If it		1 Buriel 2 Moremation 3 R	lemoval from Stat	е	cemetery, c	Metro (-	07/10/99	Ball	timore,	Maryland
Balti Demit.			21. Signature of Fund al Service Licens	601			22. Name		ss of Fecility				
ш «	D S E A		Willenlattin S	he M	5-300			3871 C	Funeral Hom Old Columbia	e, P.A. Pike Ellico	ott City, MD	21043	
	nysiclan		23 Pert1. Enter the disease, or complishock, or heart feilure. List only or	cations that cause ne ceuse on each	ed the dee line.	th. Do not e	enter the m	ode of dyin	ig, such es cardiac	or respiratory a	rrest,	1	Approximate Interval Between Onset end Death
	Medicai kaminer	1	Immediete Cause (Final disease or condition resulting in death)	pheum	Emm								Ays
	-	ner		metris		Or as a cons	sequence o	1):	Lung	Any Br			(1)
acuted	and -trensi	Examiner	Sequentially list conditions,) Wet-3		or as e cons	sequence of	l):		0.11-001			Jus
68760, filcate be executed	physician end s the burial-trensit	al E	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events										
687	g phys	edical	resulting In deeth) Lest		Due to (or es a cons	equence of):				1	
Box ath cert	attending	Physiclan/M		J									
. O . E	the at thed fo	ysici	Part II. Other eignificant conditions con	tributing to death	but not res	sulting in the	underlying	cause giv	en in Pert I.	23b. Dld	tobacco use co	ntribute to	the cause of dea
P.O. that the	ed by the detached	y Ph	Hypertenme Ite	out Dis	ensiz					10	Yee 2□ No	3 00	ably 4 Unkn
MUCME I Records, P.O. Box 6 The law requires that the death certif	been signed should be del	ed by	/ /								en eutopsy	24b. We	ere eutopsy finding
2 0 %	has been ge 2 shoul	Completed								perio	omed?	COF	npletion of cause deeth?
E E	- 4	Com								10	Yes 2 No	1 🗆	Yes 20 No
of Vita	s certificate director, pag	Be	25. Was case referred to medical examiner?	lospitel:				Oth	26. Place of Dea	th (Check only o	one)		
of Phys	raldi	. To	1 Yes No	28e. Date of In		28b. Time			4 Li Ivursing H		dence 6 Oth		1)
Vision	ath. r: After th	ation	1 Returel 5 Pending Investigation	(Month, D	ley Yeer)	Injur	М	28c. Injur Wor 1 □	k? Yes 2□No				
$\mathcal{M} \cup \mathcal{L} \mathcal{A}$ Division of Vital Records, 4 or Attending Physician: The law requires the	efter de Directo d in by th	Certification:	3 Suicide 6 Could not be determined	28e. Plece of li building, e	njury - At h	ome, farm,	street, facto	ory, office		28f. Location (City or To	Street end Numb wn, Stete)	er or Rural	Route Number,
Hospita	within 24 hours effer death. To the Funeral Director: A completely filled in by the fr	edical C	29a. Certifier (Check only one) Certifying Physical Example (Check only one)	lician: To the bes ner: On the basis and manner s	of examine	owledge, de etion end/or	eth occurre Investigetion	d et the tin	ne, date end plece, plnion, death occur	end due to the red et the time,	ceuse(s) end me dete and piece,	enner as sto end due to	ated. the cause(s)
Tothe	within To the compl	Me	29b. Signature and title of vertition				2	9c. Licens	e number		29d. Date signe	d (Month, L	Dey, Year)
			XXX refreen	>				D-3	74868		July 8	,199	5
		1		mpleted cause of	death (Ite	m 23a) (Typ	e, Print)	0	74868 HUT PK	41	,	/A . S	2
			Disier, Start		Mor	LIT	TIL	1/2/24	sent 11C	- Colu	ulbiot,	W ()	21044



The law requires that the death certificate be executed Box 68760. P.O. Records, Division of Vital

filed within 72 hours after

21215-0020

Baltimore, Maryland

or Attending Physician: 24 hours after death.

Funeral Director: A Hospital To the F within 2 6

> State Registrar

(Check only one)

ALPANA

29b. Signeture and title of certifier

30. Nema and address of person who completed cause of deeth (Item 23a) (Type, Print) M.D GUNLAMI 31. Dete filed (Month, Day, Year) JUN 3 0

1999

2 Medical Examiner: On the basis of examend menner stated.

CONNETICUE AVE, 1099 32. Registrer's Signeture

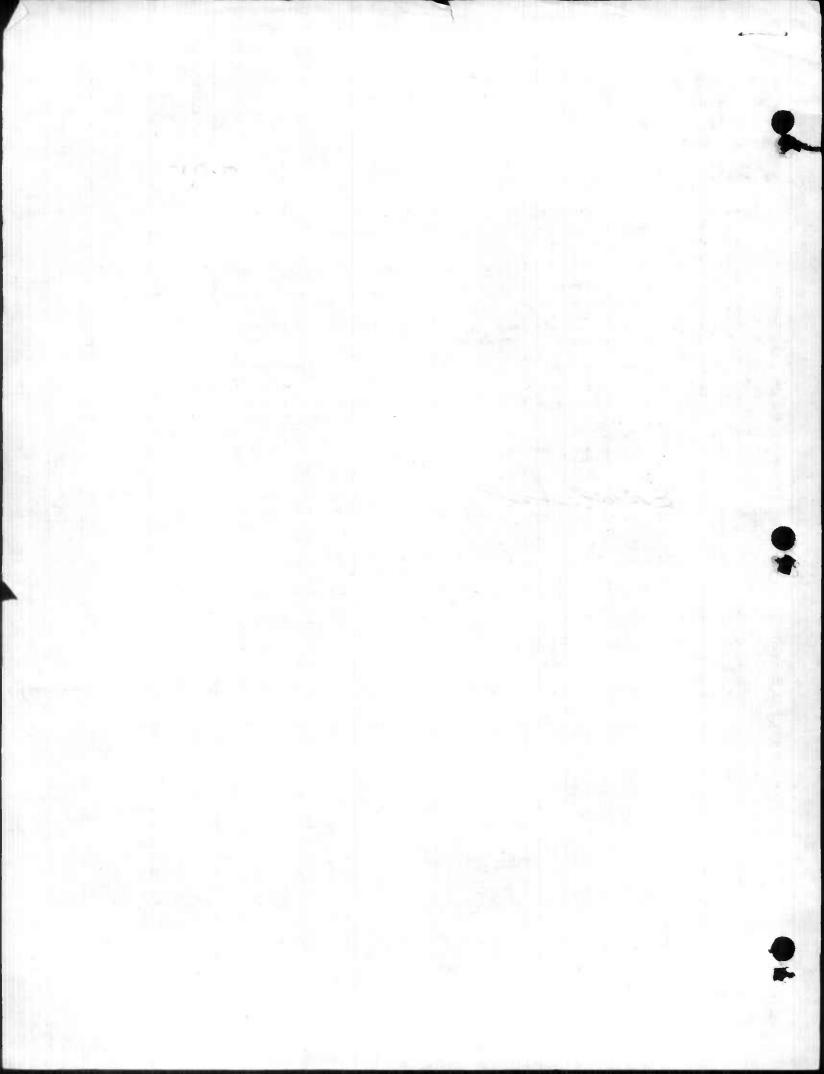
MO

29c. License number

D-27660

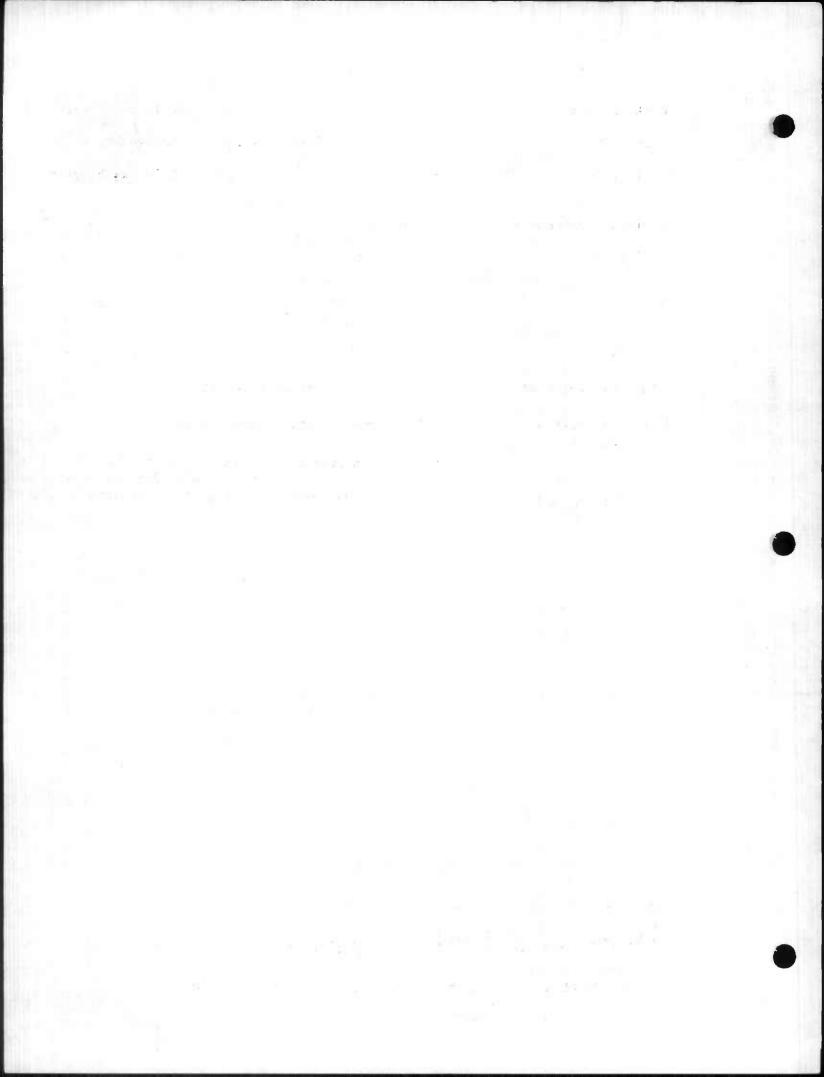
29d. Date signed (Month, Day, Year)

KENSINGTON, MD 20895



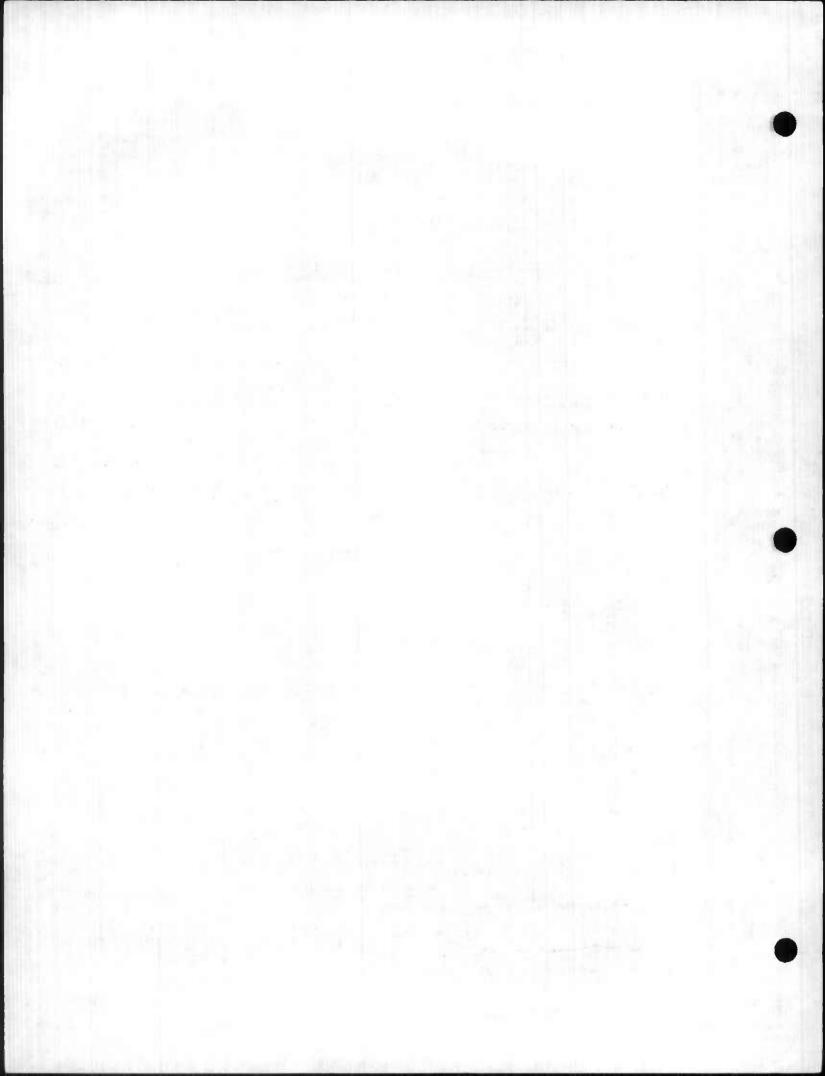
State of Maryland / Department of Health and Mental Hygiene

					,	Cer	tificat	e of	Death		R	leg. No.	J	219/1
	Dharia		1. Decedent'a Name (First, Middla, Las	st)							2. Date of Dea Month		Year	3. Tima of Death
	Physici /Medi		JULIA B. AIKEN									23 , 199		11:40 PM
	Examir		4a. Facility Nama (If not Institution, give	e street and number))				4b. City, To	own, or Lo	cation of Death	4c. County	of Death	
			Friends House					-	Sandy			Montg	omer	у
	Funeral Director		5. Social Security Number 6. S 718-10-7448 Usual Residence of Decedent	ex 7. Ag ☐ M 2 🕮 F	ga (In yrs. last b	irthday) Yrs.	If Under Months	1 Yaar Days		24 Hrs. Min.	8. Data of Birth (Month, Day Apr 14	Year) , 1916	9. Birthr Cour Was	placa (Stata or Foreign http:// hington, DC
	Anyland f show ad at	or	10a. State 10b. County		10c. City, To								1	10d. inside City Limits
	288-	ect	Maryland Montgo 10e. Street and Number	mery	Sandy	Spr	10f. Zip	Code				Og. Citizen of V	What Cour	
	With Se or	Funeral Director	17340 Quaker Ln					860				USA	viiat Oodi	my r
	ma 2	Jera	11. Marital Status	12. Was Dacedent		13. V			Hispanic Or	igin? (Spe	ecify Yes or No- Rican, etc.)		a - Americ	can Indian,
21215-0020	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hyglene. tem 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic event, the Medical Exampler must be notified at	þ	1 Nevar Married 2 Married 3 ₩ Widowed 4 Divorced	Armed Forces? 1 ☐ Yas 2 ☑ If Yes, Give Yaar or Dates:					Specify:		Rican, etc.)	Specify	white, Wh:	atc. ite
5-0	72 ho	ted	15. Decedent's Ed (Specify only highast gra	lucation	16	. Deced	lent's Usua	ai Occu	pation during mos	et of work	ina	16b. Kind of Bu	sinass/In	dustry
2	ighin Maria	Completed	Eiementary/Secondary (0-12)	Coilege (1-4or	5+)	life. L	OO NOT u	se retire	ed)	H OF WORK	ng .			
	2 should be filled withir and Mental Hygiena. is marked other than sumatic svant, the Me		12		S	ecre	tery					Cleric		ffice
Maryland	d off	Be	17. Father's Name (First, Middle, Last)								aeffer	Ma <i>id</i> an Su <i>rnam</i>	10)	
Z	2 should be fi and Mental It is marked of summits avail	10	Thomas W. Blumen			h	- 4	(0)						
Ma	d2s than 7 is r		19e. Informant's Name/Relationship (1) Gary S. Aiken/So								al Route Number on, VA		State, Zip	Code)
e,	of Haalth Item 27		20a. Method of Disposition	111	20b. Piaca					Kest		20c. Location -	City or To	own. State
JOIL	ages ant of t: If It y or o		1 ☐ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			-				-				
Baltimore,	permit. Pages Department of Firmportant: If the any injury or of page.		21. Signature of Funeral Sarvice Licen	<u> </u>	FOIL			-	emator ess of Facili	-	Jun 25 es-Rina	Brent 1di Fun		
B B	Depa Impo	Ш	1 along T	Donnell		11	.800	New	Hamps	hire	Ave, S	ilver S		g, MD 20904
			23a. Part1. Enter the discase, ir comp shock, or heart fail re. List only of	plications that causar one cause on each ii	d the death. Do ine.	not ante	ar tha mod	la of dy	ng, such as	cardiac o	or raspiratory arr	est,		Approximate Interval Between Onset and Death
	Physician /Medicai		Immediate Cause (Ftnai				0	ΛΛ.	10-			0	Í	Onset and Death
	Examiner		disaasa or condition resulting in death)	· Antenic	SCOR	one	5 (MU	01000	3000	W OL	onst.		
		ē			Due to (or as a	conseq	uence of):						1	
	d d ansit	Examiner	Server tiethy that any distance	b	Due to (or as a	coneca	unnon of):						1	
o,	an an		Sequentially list conditiona, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury		200 10 (01 20 2	oonsoq	aonoo oij.						1	
68760,	icate be executed physician and s the buriel-transit	lical	Cause (Disease or Injury that Initiated events resulting In death) Last	C	Dua to (or as a	consequ	uenca of):					<u> </u>		
	5 0 6	Physician/Medical	Joseph Jacks J. Last										ŧ	
Box	eath cer attendin	lan		d										
0	tha a	ysic	Part II. Other significant conditions co	ontributing to death b	ut not resulting	in the ur	derlying c	ause gi	van in Part	l.	23b. Did to	obacco use cor	ntribute te	o the cause of death?
a	The law requires that the de- ate has been signed by the a page 2 should be detached f										1□ Y	es 2000	3 Pro	bably 4 Unknown
Records,	ngis r	d by									24a. Was s	n autopsy	24b. W	ere autopsy findings
00	w requin	Completed									perfor	med?	CO	railable prior to empletion of causa death?
æ	The lay ata has paga 2	E C									1 🗆 Y	200		Yes 20 No
Vital		BeC	25. Was case referred to medical						26 Place	of Deeth	(Check only or		11	
2		0	evermor?	Hospital:	ent 2 ER/O	utpatien	3 DC	OA OI			me 5 Resid		er (Specif	(v)
ιof	g Physical distribution	ı.	27. Menner of Death	28a. Date of Inju (Month, Da	ry 28b.	Time of Injury		8c. Inju			28d. Describe h			,,,
<u>Ö</u>	Attending at death. ector: After by the fune	atic	1 Natural 5 Pending investigation	7500000	, , , ,	ii ijoi y	М		Yes 2□	No				
Division	al or Attanding Ph s after death. Il Director: After th ed in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inj building, etc	ury - At home, f	arm, stre	at, factory	, office	2	1	28f. Location (S City or Town		er or Rura	al Routa Number,
	tra of rail of													
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by the	edicai	29a. Certifying Phy 28 Medical Exam	sician: To the best of the basis of	f examination at	e, death	occurred estigation	at the ti	ma, dete an	d place, a	and due to the c	ause(s) and ma ate and place, a	nner as s	tated. o tha cause(a)
	thin the	Mec	29b. Signature and title of certifier	and manner ste	atad.		290	Licen	se number		2	9d. Data signed	1 /Month	Day Year)
	E 3 # 8			n.o. (0)Mt)				236			Just "		
	8		20 Name and address of service 1	and the same of the	/	CT.		017	000			3006	- 11	
	_		30. Neme and address of person who c	-	, ,			11	Do ole-	.111_	MD 30	952		
	Sta	te	CARL MARGOLIS 31. Data filed (Month, Dey, Year)	32. Registra	OCKVIII ar's Signature	e rr	11 Z	11,	KOCK.V	ттте	, MD ZU	072		
	Registr	_	JUN 2 8 1999		va.	4	1							



State of Maryland / Department of Health and Mental Hygiene 99 21972

		Cel	titicate of	Death	R	eg. No.	7 5 4
Physician /Medical	1. Decedent's Nema (First, Middle, Last) HAYQLABET AK DEM	iR	. 5411		2. Dete of Dea Month	Day	Yeer 1906
Examiner	4e Facility Nama (If not Institution, give street and number) SUBURBAW HOSPITAL			4b. City, Town, or Le	ocation of Deeth	4c. County o	Death Som CNY
Funeral Director	1 M 2 F	(In yrs. last birthdey) 49 Yrs.	If Under 1 Yaar Months Days	Hours Min.	8. Dete of Birth (Month, Dey September	Year) 10,1949	9. Birthplaca (State or Foreig Country) Turkey
s or 28e-f show be notified at Director	The state of the s	10c. City, Town or Lo	cation				10d. Inside City Limit
renous and country and the material of the field Examiner must be notified the by Furneral Directo	10e. Street and Number 102 Tapawingo Road, SW 11. Marital Status 1 X Never Merried 2 Merried 11 Yes, Give	0	10f. Zip Code 2218 Wes Decedent of f Yes, specify Cut	Hispanic Origin? (Sp ban, Mexican, Puerto			
ver than "natural" r, the Medical Ex Completed b	3 Wildowed 4 Divorced Year or Datas: 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5-1)	(Give	lent's Usuel Occu kind of work done DO NOT use retire	pation a during most of work ad)	ing	16b. Kind of Bus	White iness/Industry
whental H sirked oth sife even To Be	17. Father's Name (First, Middle, Last) Nisan Akdemir		Attenda	18. Mother's Nem	e (First, Middle, I		
vent of Health and Int. If Nem 27 Is ma Int. or other trauma	19a. Informant's Neme/Reletionship (Type, Print) Aghajan Tufeckgian/brother-in 20a. Method of Disposition 1 ⊠ Burial 2 □ Cramation 3 □ Removal from State 4 □ Donetion 5 □ Othar (Specify)	1-law 101 T	apawingo sition (Neme of netory or other pla	July 1, 1	, Vienna Dete 999	, Virgi	
nysician Medical kaminer	23a. Part1. Enter the disease, or complications that caused in shock, or heart failure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death)	tha death. Do not ent	57 Wiscons or the mode of dy	mphrey Funer sin Avenue, I ing, such es cardiac	Bethesda, or respiratory arr	Maryland	Chevy Chase, Inc 20814-3501 Approximate Interval Between Onset and Death
nding physician and use as the burial-transit in/Medical Examiner	if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or es e consequente to (or as a consequente to (or a consequente to (or a consequente to (or a consequente to (or a consequente to (or a consequente to (or a consequente to (or a consequente to (or a consequente to (or a consequente to (or a consequente to (or a consequente to (or a consequente to (or a consequente to (or a consequente to (or a consequente to (or a consequente to (or a consequente to (or a consequente to (or a		J.F			
d by the atte letached for Physicia	Pert II. Other significant conditions contributing to death but	t not resulting in the ur	nderlying cause g	iven in Pert I.			tributs to the cause of deat
2 should					24e. Wes e parton	n eutopsy med?	24b. Wara autopsy finding: available prior to completion of causa of death?
rector,	25. Was case referred to medical avaminar? Hospitel:		-5	26. Plece of Deet		10)	1□Yas 2No
ther th meral	27. Menner of Death 1 Naturel 2 Accident investigation 3 Suicide 6 Could not be	Year) 28b. Time of Injury	28c. inju	4 □ Nursing Ho	ma 5 ☐ Reside 28d. Describe he	ow injury occurre	
within 24 hours after death. To the Funeral Director: A completely filled in by the the Medical Certificati	4 Homicide determined 2299. Prece of Injurious building, etc. 299. Certification (Characteristics) Medicat Examiner: On the basis of a control of the basis of the basis of a control of the basis of the basis of a control of the basis of the basis of a control of the basis of a control of the basis of the basis of the basis of a control of the basis of t	my knowledge, deeth	occurred et the t	ime, date end place,	City or Town	n, Stete) ause(s) end men	ner es stated
To the Fi	29b. Signeture and title of certifier)ME)	29c. Licen	se number	2		(Month, Day, Year)
	30. Nema and address of parson who completed cause of decoder I MARGOLY , MO. (Or	ath (Item 23a) (Type, 1	Print)	3 Pice, Do	CEVILLE	Mon	0852
State Registrar	31. Dete filed (Month, Day, Year) JUN 2 9 1999 32. Registrer	4- 01	Spork				-18-18



31. Data tiled (Month, Day, Year)

29b. Signeture and title of certifian

and

JUN 28 1999

LAPRY WATERBURY hD

Watebury

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAPRY WATERBURY NO INBAC 4946

32. Registrar's Signatura

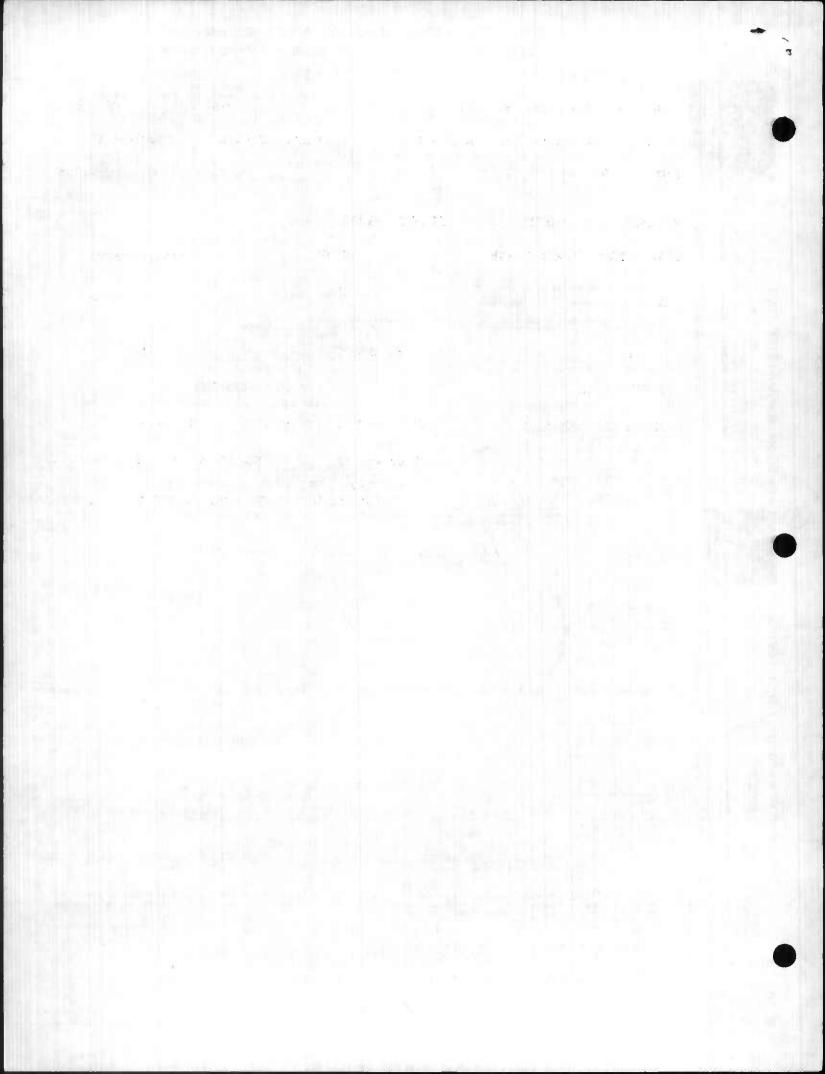
29c. Licanse number

4940 EASTERN AUR. BALT., MD. 21224

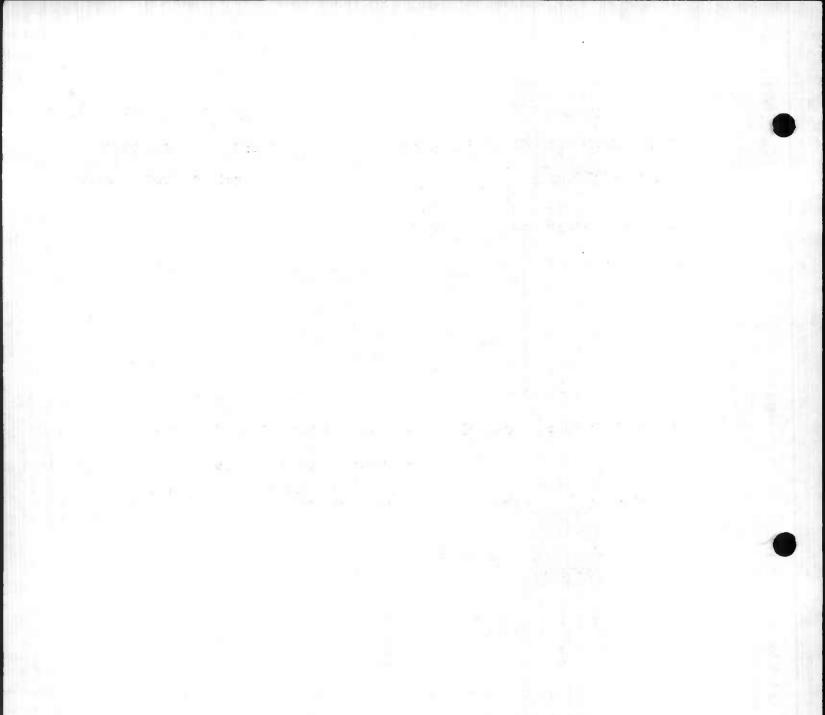
29d. Data signad (Month, Day, Year)

State

Registrar

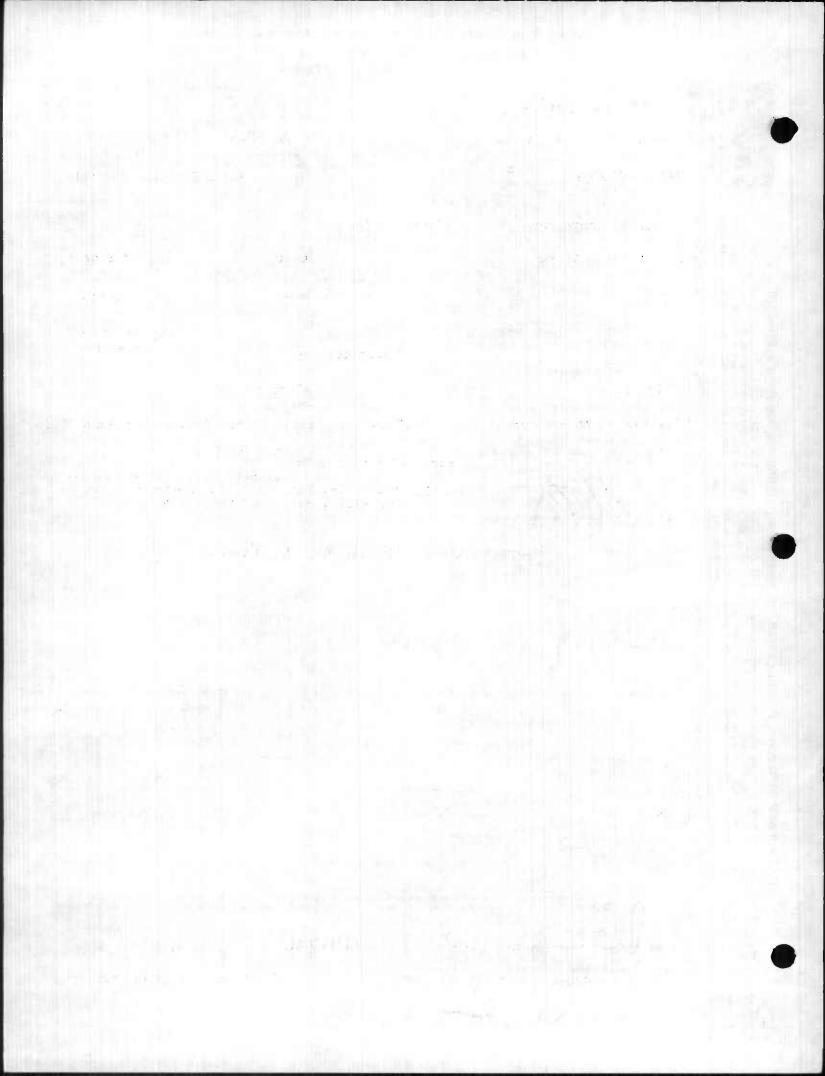


## ASUNCION ALVAREZ ## ASIGNLY Name (from institution, pies ament and number) ## AS CITY Town, or Location of Death ## AC City, Town, or Location of Death ## AC City, Town, or Location of Death ## AC City, Town, or Location of Death ## AC City, Town, or Location of Death ## AC City, Town, or Location of Death ## AC City, Town, or Location of Death ## AC City, Town, or Location of Death ## AC City, Town, or Location of Death ## AC City, Town, or Location of Death ## AC City, Town, or Location of Death ## AC City, Town, or Location of Death ## AC City, Town, or Location of Death ## AC City, Town, or Location ## AC City, Town, State ## AC City, Town, Or Location ## AC City, Town, Or Location ## AC City, Town, Or Location ## AC City, Town, Or Location ## AC City, Town, State ## AC City, Town, State ## AC City, Town, State ## AC City, Town, State ## AC City, Town, St					Certific	cate of L	Death		Reg. No.		1 12 1
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SHADY GROVE ADVENTIST HOSPITAL Shadil Security number 1. Social Security number of number in the security											0325
5. Social Sacothy Number 6. Sex: IDM 20 F 100 CPt, Town or Location 93 T 20 Sex Sex Sex Sex Sex Sex Sex Sex Sex Sex	Examir	ner				41	b. City, Town, or L	ocation of Death	4c. County	of Death	
215-62-8925 IDM 2014 93 Vrs. Months Days Note: Mrs. (Aborth Evy Year) Spain. 215-62-8925 IDM 2014 93 Vrs. Months Days Note: Live In Production Completed Co					The second secon				MONTO	GOME	RY
10 10 10 10 10 10 10 10	Funeral		1DM	21√F	Mon					9. Birthpia Country	ce (Stete or Fo y)
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15. Decadents Education 16a. Decadent 15a Dec	- 5	to	Maryland Montgomer		11 C						1 ☐ Yes 2 §
15. Decadents Education 16a. Decadent 15a Dec	28	rec		у					10g. Citizen of W	hat Countr	y?
15. Decadents Education 16a. Decadent 15a Dec	9 3 3 8 9 8 9 8 9 8 9 8 9 8 9 8 9 8 9 8		1/00 Farrial Lane	71/		00010					
15. Decadents Education 16a. Decadents Usual Occupation 16b. Kind of BusinessAndesity 16b. Mail Research 16b. Mail Resea	E E	ner	11. Marital Status 12. 1	Was Decedent Ever In U.S.	6. 13. Was D	ecedent of His	spanic Origin? (Sc	pecify Yes or No			
15. Decadents Education 16a. Decadent 15a Dec	유류		1 ☐ Never Married 2 ☐ Married	I ☐ Yes 2 ☑ No				Rican, etc.)	4 8	100	c.
15. Decadent's Education (Spandy) only highest prace completed) 16. Decadent's Education (Spandy) only highest prace completed) 17. Farber's Name (First, Middle, Last) 17. Farber's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) 19. The Informatic Name (First, Middle, Last) 19. The Informatic Name (First, Middle, Last) 19. The Informatic Name (First, Middle, Last) 19. The Informatic Name (First, Middle, Last) 19. The Informatic Name (First, Middle, Last) 19. The Informatic Name (First, Middle, Last) 19. The Informatic Name (First, Middle, Last) 19. The Informatic Name (First, Middle, Makista) 19. Member of Disposition (Spandy) on the Informatic Name (First, Middle, Makista) 19. Member of Disposition (Spandy) on the Informatic Name (First, Middle, Makista) 19. Member of Name of	II.				1 K Ye	es 2⊔№ Spanish	Specify:		Specify:		. 0
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21. Signature of Funeral Service Licensee 22. Name and Address of Recility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 2091 23a Part I. Spect the disease, or complications that cabeled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inflavarial Bewer Ones and Death Season or conditions or conditions as a consequence of): 10	or the			oval from State ce.	intelety, cremetory	or other prace	7/				
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	Toth		29b. Signature and title of certifier			29c. License	number		29d. Date signed	(Month, De	ay, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Eigz, M.D. 8609 2nd Ave # 404B Silver SPring M.D. 209/2	/		plut 9in	Phyeiria		Dans	50055		luno a	4	1999
M. Eigz. MD. 8609 and Ave #404B Silver SPring MD 209/2	P		30. Name and address of person who complete	eled cause of death (Item	23a) (Type, Print)	,00	1 6677	0	14118 2	72 /	111
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Medical Medical Investor Inves	TANICE S. AND GRSON 4e Facility Name (If not institution, give street and number) 4b. City		onth Day	Year Mnch
xaminer ineral ector	4e Facility Neme (If not institution, give street end number) 4b. City) '	NA 54	1999 0757
ector	HOLY CROSS HOSPITON SIL	ity, Town, or Location Opinion		ty of Death
E	506-14-4297-A 1□ M 202F 81 Yrs. Months Days Hou		ete of Birth onth, Day, Year) 11 23, 1918	Birthplace (State or Foreign Country) Nebraska
	Usual Residence of Decedent 10a. Stele 10b. County 10c. City, Town or Location			10d. Inside City Limits
tor	Maryland Montgomery Silver Spring			1 ☐ Yes 2 No
Directo	10e. Street and Number 10f. Zip Code		10g. Citizen of	What Country?
		0910		ed States
by Funeral	11. Maritel Status 1 □ Never Merried 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates: 13. Was Decedent of Hispank if Yes, specify Cuban, Merity C		etc.) Bi	ice - American Indian, ack, White, etc. ify: White
eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during	n na most of working		Business/Industry
Completed	Elementary/Secondary (0-12) Coilege (1-4or 5+) 7 Statistician			ed States rnment
	•		t, Middle, Maiden Suma	ime)
To Be	Clay Stroup F1	lorence Mc	Clain	
-5	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and No.	Number or Rural Rout	te Number, City or Town	n, State, Zip Code)
	Richard M. Anderson/Husband 8505 Sundale Driv	ive, Silver	r Spring, M	
	20a. Method of Disposition 1 X Buriei 2 Cremetion 3 Removel from State 20b. Place of Disposition (Name of cemetery, crematory or other place) July 1 Cremetery, cremetery, crematory or other place) July 1 Cremetery, cre	July 2, 199	99 20c. Location	- City or Town, State
	4 Donation 5 Other (Specify) Parklawn Memorial Pa	ark	KOCKVII	le, Maryland by Funeral Home,
800	M01126 Rockville, In Rockville, Ma 23a. Part I. En entre isease or semplications that caused the death. Do not enter the mode of dying, suc shock, or heart failure. List only one cause on each line.	nc., 300 Waryland 20	est Montgon 850-2805	nery Avenue,
er Ja	Immediate Cause (Final disease or condition resulting in death) ANTERIOS CURRENC CAROLO W3CU a. Due to (or as a consequence of):	var Oison	135	
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.	-17		
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y Phys	Part tl. Other eignificant conditions contributing to death but not resulting in the underlying cause given in f	Parti.	1 ☐ Yes 2 ☐ No	\
Completed by Physician/M		2	4a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
To Be Comp			1□ Yes 2 No	1□ Yes 20 No
Be	examiner?	3. Place of Death (Che	eck only one)	
P O	VS Yes 2□ No Hospital: 1□ Inpatient 2X ER/Outpatient 3□ DOA Other: 4[Residence 6 0	
Certification:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Sulcide 6 ☐ Could not be	2 🗆 No	escribe how injury occ	
Certifi	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	281. Lo	ocation (Street and Nur ity or Town, State)	nber or Rural Route Number,
edical	29a. Certifier (Check Only one) 1 Certifying Phyatcian: To the best of my knowledge, death occurred at the time, da commendation and/or investigation, in my opinion and manner stated.	on, death occurred at t		
completely filled in by the funerel director, Medical Certification: To Be (29t. Signature and little of certifier (ont) 29c. License num 01523			27, 1999
	30. Name and address of person who completed cause of death (tem 23a) (Type, Print) CALL I. MARGOLI, MD. (DMb) 11125 Pockulus (RIKE, Pro	KVILLE ME	10852

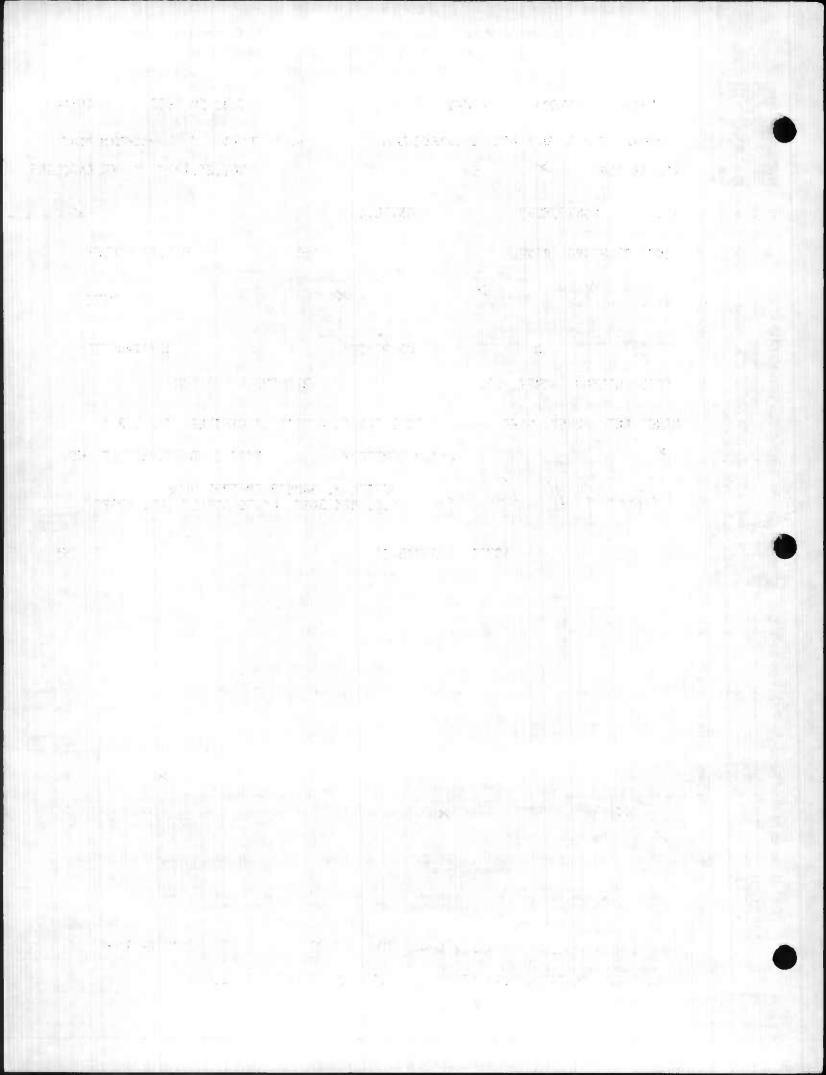


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JUNE 28, 1999 Physician REID JR. 16:44 WILSON ARNEY /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth NOV. 24, 1939 9. Birthplace (State or Foreign NORTH CAROLINA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 100M 20F Months Days Hours Min. 215 36 3365 59 **Director** Usuai Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic avant, the Medical Examiner must be notified at page. 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MONTGOMERY ROCKVILLE MD. Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20851 1021 CRAWFORD DRIVE UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) CARPENTER CONSTRUCTION 18 Mother's Neme /First Middle Maiden Sumame 17. Father's Name (First, Middle, Last) Be WATSON REID WILSON ARNEY, SR. BLANCHE 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1021 CRAWFORD DRIVE, ROCKVILLE, MD. 20851 NANCY RUTH ARNEY, WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State UNION CEMETERY 7/2/99 BURTONSVILLE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882

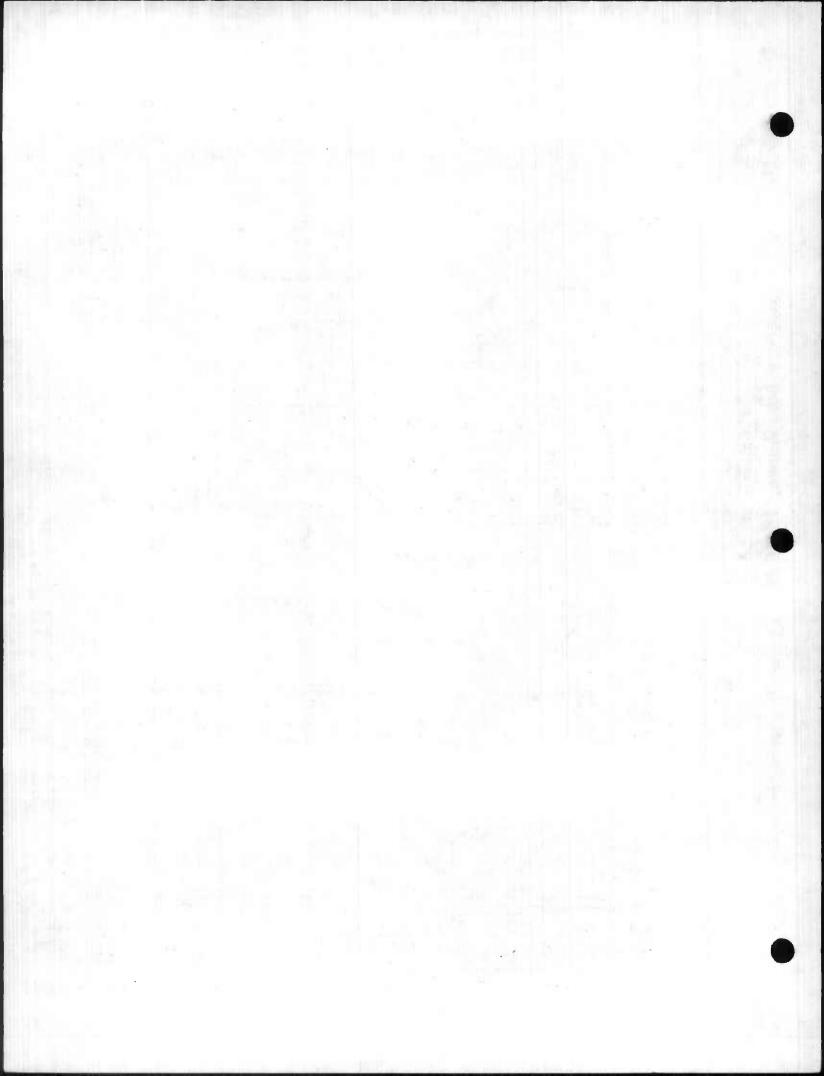
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, ahock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical ACUTE ARRHYTHMIA MINUTES Examiner Due to (or es a consequence of): Examiner death certificate be executed attending physician end for use as the bunal-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) 88 for P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Munknown signed b Division of Vital Records, by 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? page 2 s has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attanding Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: After 1 Natural 5 Pending 1 Yes 2 No 24 hours efter death. Investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospital 29e. Certifier 🔀 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated. edical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig 29c, License number MI 53887 JUNE 29,1999 30. Neme and eddress of person who com eted cause of deeth (Item 23e) (Type, Print) DR. ORLEE PANITCH 11824 DINWIDDIE DRIVE, ROCKVILLE, MD. 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State JUN 3 0

DHMH 16 Rev 6/95

Registrar



		State of Maryland / Department of Certificate of			ene g. No.	21977
	hysician /Medical	1. Decedent's Name (First, Middla, Last) Alice B. Ayco	ock	2. Date of Death Month June 29	Day Yes	3. Time of Death 5:30 AM
Fu	Examiner	4a Facility Nama (If not institution, give street and number) Collingswood Nursing Center 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 1 Under 1 Yaa 577-22-7853 1 Mark 2 1			4c. County of D Montgor 9.1 1908 No	
2		Usual Rasidanca of Decedant 10a. Stele 10b. County 10c. City, Town or Location				10d. tnside City Limits
with the Maryland	fied a	Maryland Montgomery Garrett Park				1 Yas 2 □ No
84 1	e noti	10e. Street and Number 10f. Zip Code		10	g. Citizen of What	Country?
6	ral mith	11004 Montrose Avenue 20896			Jnited St	
5-0020 72 hours after de	ar, or terms 23s or 28s-f short Examiner must be notified at by Funeral Director	11. Marital Status 1 Nevar Merried 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Ever in U,S. Armed Forcas? 1 Yes 2 No If Yes, Sive Yasr or Datas:		pecify Yes or No- b Rican, atc.)	14. Race - A Black, W Specify:	marican Indian, Thita, atc. White
Maryland 21215-0020 d 2 should be filed within 72 hours all Iffi and Mental Hygiene.	her the Medical I	15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) 1 2 16a. Decedent's Usual Occu (Giva kind of work done life. DO NOT use retire) Homemale	e during most of worl red)	king 10	6b. Kind of Busine	
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/lan	atic ever To Be	Louis Brogden	Alice B	all		
Raryis 2 should and Mer	am .	19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street				4)896
	The Tr	Catherine A. Bodine (granddaughter) P.O. Box 284	4, 11004 M		Avenue, (
Pages Pages	2 6 2 6	1 ☐ Buriel 2 ☐ Cramation 3 ☐ Ramoval trom Stata cematary, crematory or other pl				
Baitimore, semit. Pages 1 at Department of Hea	ry injury 108.	21. Signature of Funaral Sarvice Licensee, 22. Name end Addi	ress of Facility eral Servi			e, Maryland
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Geeth cert	d by the attending petached for use as Physician/Me	d	niven in Part I	23b. Did tob	acco usa contrib	uts to the cause of death?
O å	ned by the after of detached for a y Physician	Hypertension,		1 🗆 Ye	8 2⊠No 3□	Probably 4 Unknown
Cords	should be	Anemia of Chronic Disease		24a. Was an perform		lb. Wara autopsy tindings available prior to completion of cause of death?
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To the Hospital or within 24 hours after	pletely filled edical C	29a. Cartifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the 2 Medicat Examiner: On the basis of examination and/or investigation, in my and mannar stated.				
	105	De Debut Frankon 04	nse number		d. Dele signed (Mune 29,	
		30. Name and addrass of person who complated causa of death (Item 23a) Type, Print) H. Robert Birschbach, M.D., 6320 Democracy I 31. Data Iiled (Month, Day, Year) 32. Registra Signatura	4	hesda, Ma	aryland	20817
R	State Registrar	JUN 3 0 1999 > Server 19. 19	rocks			



State of Maryland / Department of Health and Mental Hygiene

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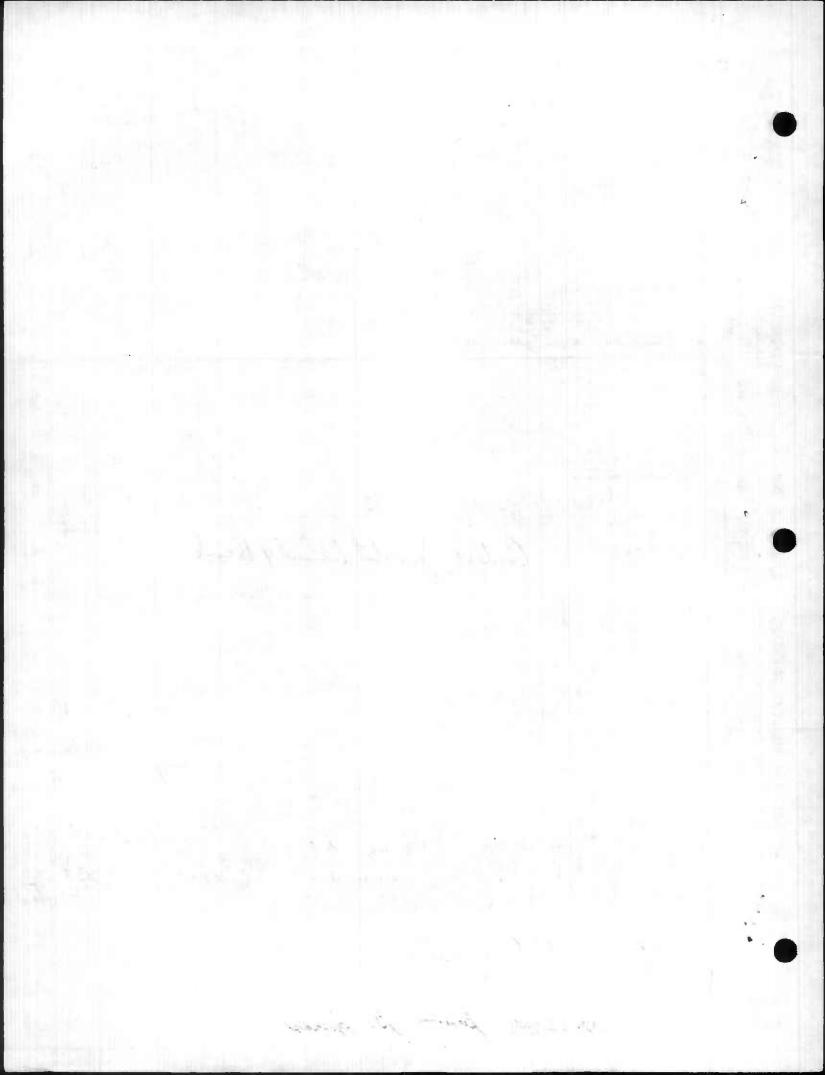
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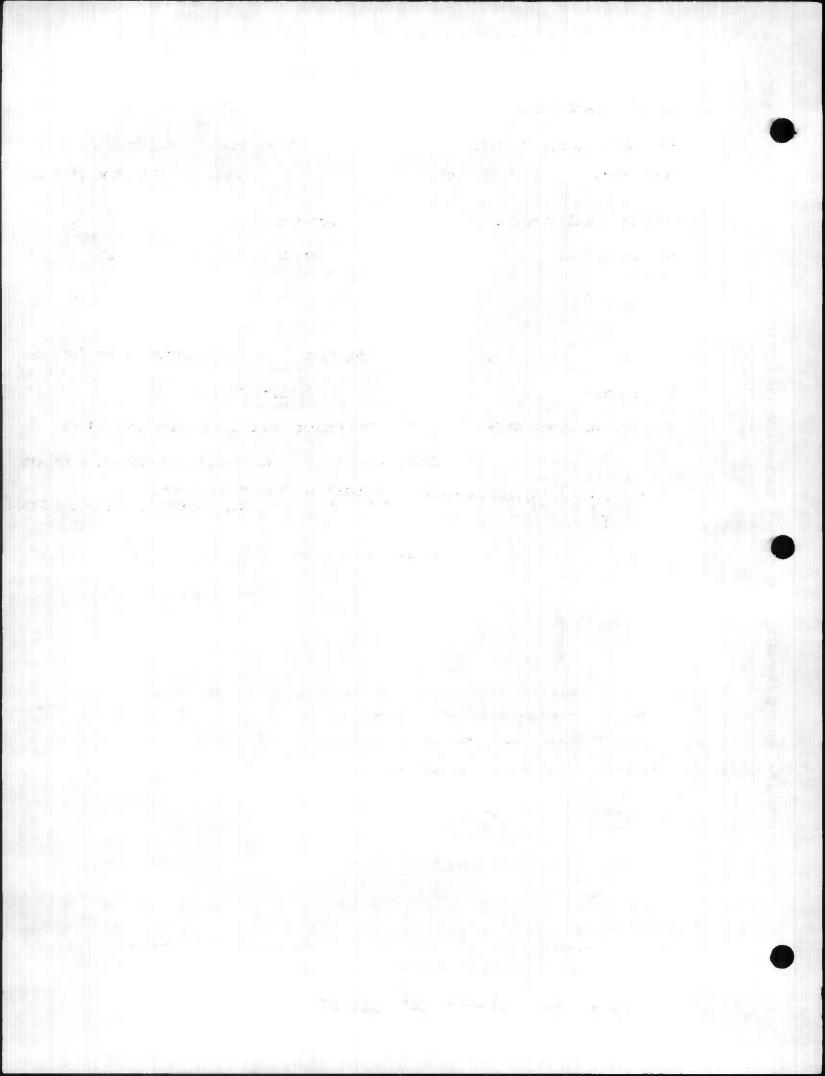
DHMH 16 Ray 6/95

ORIGINAL



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	/Medical Examiner	4e Facility Neme (If not institution, g	ive street end numbe	r)			4	b. City, To	wn, or Lo	cation of Deat		11		
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	Funeral	The state of the s	Sex 7. / 1 ☐ M 2 ☐ F		last birthday) Yrs.	If Under Months	1 Yeer Deys	If Under 2 Hours	Min.	(Month, De	y, Year)	9. Birthp	lece (Ste try)	te or Foreign
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	Jend was	10a. Stete 10b. County		10c. City	y, Town or Lo	cation						1	Od. Inside	e City Limits
	Many Hang	Maryland Washing	ton Co.				Ha	gerst	own				17	res 2□No
	hours after death with the Manyland turel", or items 23a or 28e-f show at Everyland be notified at ed by Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of V	Whet Coun	itry?	
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	r items 23s niner must	11. Marital Stetus	12. Wes Deceder Armed Forces	57	S. 13.	Wes Deced	dent of H cify Cube	ispanic Orig	gin? (Spo	ecify Yes or No Rican, etc.)	- 14. Rec Blee	e - Americ ck, White,		١,
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	be filed value of other pevent, prevent, 17. Fether's Neme (First, Middle, La.	st)					18. Mothe	r's Name	(First, Middle	Maiden Suman	ne)	-		
/ai	0 % D . W	Roy B. Brown						Cla	ara	Hawk				
Maryland	d 2 should th and Mer 7 is merke trsumatic	19a. Informent's Name/Reletionship	(Type, Print)		19b. Meili	ng Address	s (Street	en <i>d Numbe</i>	or Run	el Route Numb	er, City or Town,	State, Zip	Code)	
	CHNF	Geraldine B. Bro	wn, Wife		948	View	Str	eet,_	Hage		Maryla	nd 2	1740	
Ore	Peges 1 enert of Hez int: If item iry or othe	20e. Method of Disposition 172 Buriel 2 Cremetion 3	☐Removel from Stell	le C	lace of Dispo emetery, crea	matory or o	other place		i	Date	20c. Location	- City or To	wn, State	9
Baltimore,	permit. Peges Depertment of Important: If i any Injury or ance.	4 Donation 5 Other (Spec		C						June29	Hagers	town,	Mar	yland
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	be executed sicien and burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying	b	Due to (o	r es e consec	quenca of):	;	•						
687	g physicie as the bur	Cause (Disease or Injury that initiated events	C	Due to (or	r es e consec	quence of):								
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ds	5 5 A		n seat u	Kean	N FR	Men				24e. Wes	en eutopsy	24b. W	ere eutop	sy findings
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		30. Neme and eddress of person wh		I dooth /tte-	23e\ /T-m-	Drint\				1		,	,	
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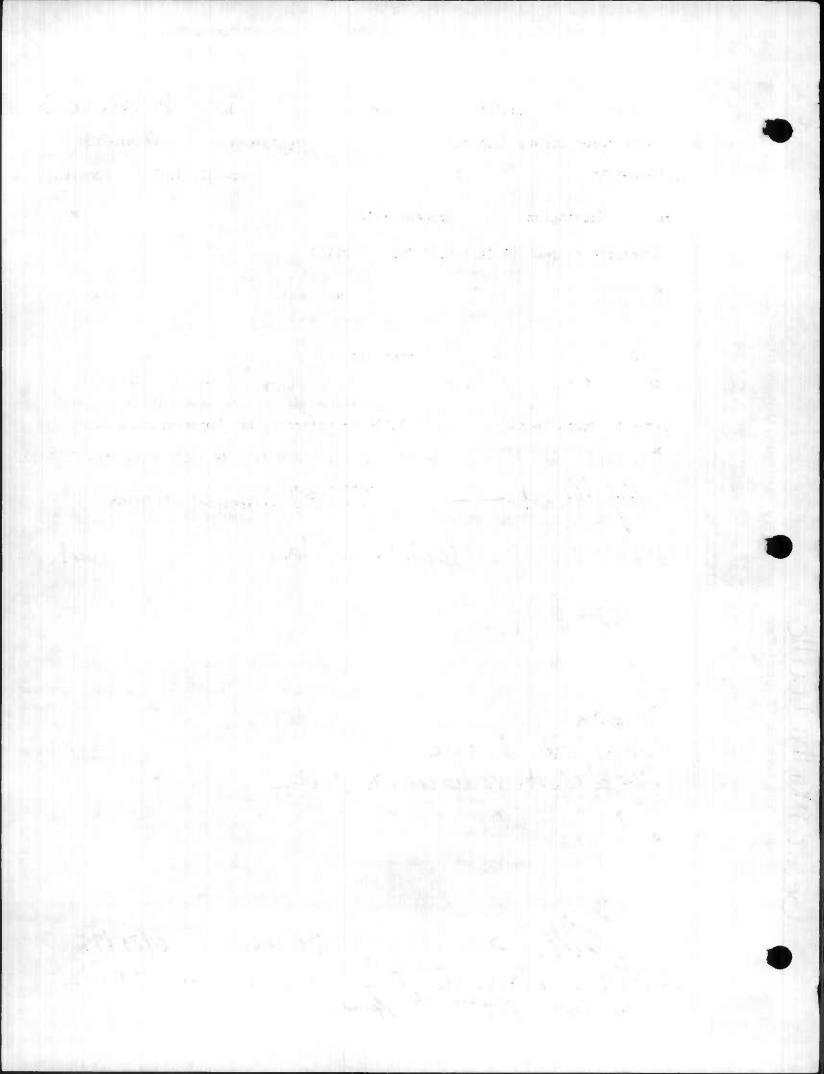
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death **Physician** 1999 BEARD Martha Lucille /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital WASHINGTON Hagerstown If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 5 F Months Director 215-14-2332 Jan.17, 1917 Maryland Usual Residence of Decedent the Marylend 10a. State 10c. City. Town or Location 10d. inside City Limits 10b. County r 28a-f show MD Washington 1 Yas 2 No Maugansville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with r than "natural", or itsms 23s or the Wedical Examiner must be Charlotte's Home 21767 Village Mill Ave. USA death Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ™ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Ricen, etc.) 14. Race - Amarican Indian. Black, Whita, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) Peges 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Homemaker Home 17 Father's Neme (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Feidt Beard Frush Lucy May 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Jerry A. Beard (son) 16819 Broadfording Rd. Hagerstown, MD 21740 other 1 20a. Method of Disposition 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ortant: If I 1 ■ Burial 2 □ Cremation 3 □ Removal from State Department of Important: If sny injury or Rose Hill Cemetery Jun. 28, 1999 Clear Spring, MD 21722 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility OSBORNE FUNERAL HOME P.O.Box # 348 Williamsport, MD 21795 he diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast in feilure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting In death) Examiner Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): use as signed by the a d be deteched f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to Completed dis Case 24a. Was an autopsy performed? completion of ceuse of deeth? page 2 s odio unculos do Case 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate coscooni 25. Was case referred to medical examiner? director, Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28c. injury at Work? 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Certification: After 1 Netural 5 Pending efter death. Director: Aft 1 Yes 2 No investigation 2 Accident 6 Could not ba determined 3 Sulcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 11 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the best of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 0 Hagestern no 21742 Neme and address of person who completed ceuse of death (Item 23a) (Type, Print) > Northon 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State

DHMH 16 Rev 6/95

Registrar

JUN 2 8 1999

eard, Martha Weil



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Deta of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Nevin Leroy Brunner /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deel Examiner Washington County Hospital Hagerstown Washington If Under 1 Yaar If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Day, Year) 5. Sociel Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Deys Hours Yrs. Maryland 218-24-7743 70 May 27, 1929 Director Usuai Residence of Deceden with the Marylend 10a Stete 10b County 10c. City. Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notiled as 1 ☐ Yes 2 No Chewsville Directo Washington 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 12058 Little Antietam Rd. poemit. Pages 1 and 2 should be flied within 72 hours efter deeth v Department of Health and Mental Hypiene. Important: if item 27 is marked other than "natural", or itema 23a any highry or other traumatic event, the Men 21721 U.S.A. Funeral 12. Was Decedant Ever In U,S. Armed Forces?

X Yas 2 No
If Yes, Give
Yaar or Datas: 51-5. 14. Race - American Indien, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuben, Mexican, Puerto Rican, atc.) 1 ☐ Never Married 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: White g 3 ☐ Widowed 4 ☐ Divorced Completed 16s. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Pipe Fitter Truck Mig. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Wilbur L. Brunner Sr. Letha I. Wolfe 19b. Mailing Address (Streepand Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 12058 Little Antietam Rd. Chewsville, Md. 21721 Betty J. Brunner (Wife) 20b. Plece of Disposition (Neme of cematery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Buriai 2 Cramation 3 Remove Jrom State
□ Donetton 5 Other (Specify) Smithsburg Cemetery June 30, 1999 Smithsburg, Md. 22. Name end Address of Facility 21. Signature of Funeral Sarvice Licens 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 enno 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Physician /Medical Immediate Cause (Final disease or condition rasulting in death) Myelogenous Examiner Due to (or es a consequenca of) Physician/Medical Examiner attending physician and for use as the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequença of) Division of Vital Records, P.O. Box 68760 Due to (or es a consequence of) 23b. Did tobacco usa contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 ☑ No 3 ☐ Probably 4 ☐ Unknown BRUNNER, NEVIN by 24b. Wera autopsy findings aveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed within 24 hours after death.

To the Funeral Director: After this certificate has 2000 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 28. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of Certification: 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and dua to the ceuse(s) and menner es steted. edical (Check only one) 2 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and menner stated. 29b. Signeture and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 6.26.79 041667 nelsmal 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

State Registrar

State 31. Dete filed

32. Degistrer's Signature

McCormock

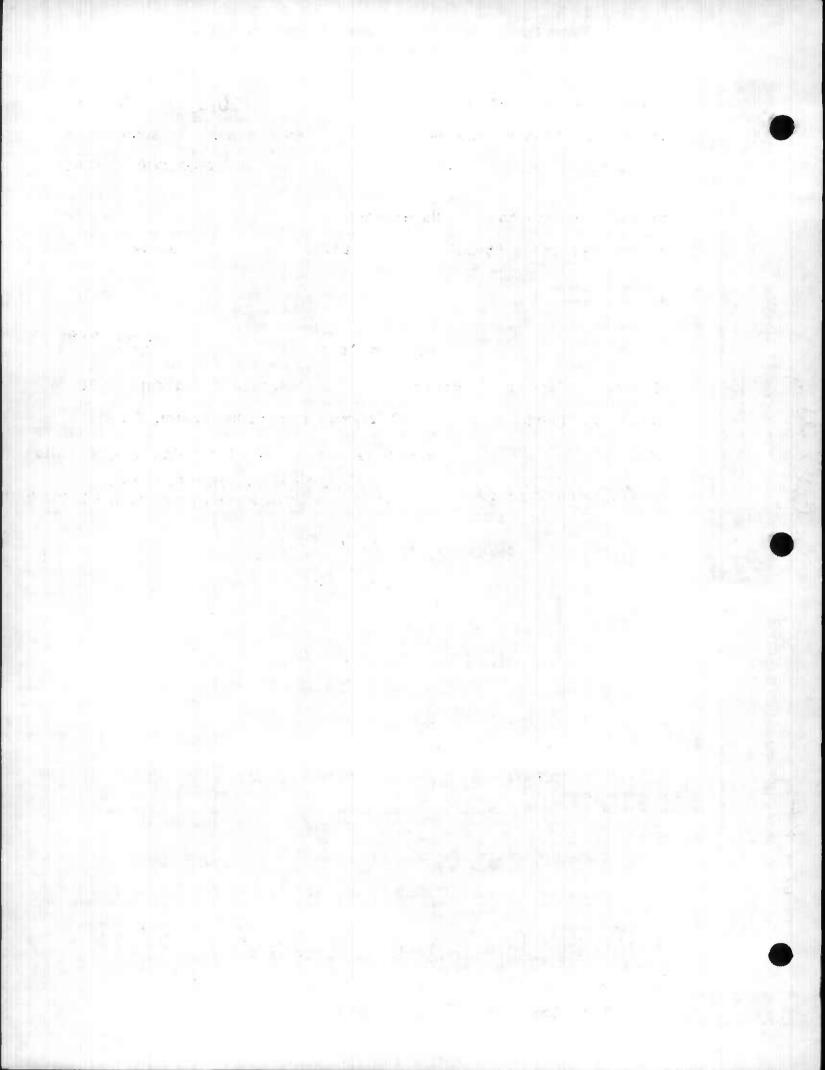
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	Funeral Director			Sex 7. /		last birthday) 98 Yrs.	if Under 1 Yaar Months Deys	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da Jan. 3	th ly, Year) 1, 1901		iece (Stata or Foreign try) na.
	show a show	ı	10a. Stata 10b. County			y, Town or Loc					1	0d. insida City Limits
	ith with the Maryland 23a or 28a-f show	I Director	MD. Washing 10e. Street end Number 12402 Burkholde		па	gersto	10f. Zip Code 2174	40		10g. Citizen of V		
020	or items	by Funeral	11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorcad	12. Was Deceder Armed Forca: 1 Yas 2 If Yas, Giva Yeer or Detes	s? ⊠No		Vas Decedent of H Yas, specify Cub	dispanic Origin? (S an, Maxican, Puerl Specify:	pecify Yes or No o Rican, etc.)	14. Race Blace Specify	k, White,	
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yland 2	S a S S	To Be Co	17. Father's Neme (First, Middle, Last Henry Burkh						ne <i>(First, Middle,</i> Horst	, Maiden Surnam		
Mar	247		19a. informant's Neme/Reletionship Edgar Burkholde					and Number or Ru 11e Rd. (
Baltimore,	二年五世		20e. Method of Disposition 1 Surial 2 Cremetion 3 [4 Donetion 5 Other (Speci	Ramovei from Ster	te	riece of Dispos em <i>etery,</i> crem	sition (Name of latory or other pla		7/3/99	20c. Location -	City or To	wn, State
Balt	permit. Peges Depertment of Important: If it any Injury or o		21. Signature of Funerel Sarvice Lice H. Martin Z	imen	~C.		45 S. (n And Sor Carlisle	St. Gr	eencast	le,	Pa. 17225
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Box 68760,	death certificate be executed a attending physician and of for use as the bunal-transit	in/Medical Examiner	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	b. AY	Due to (or	r es e consequ r as a consequ	uence of):	Pasula	(D)s	eace		
o		Physician/M	Pert ii. Other significant conditions of		,		derlylng cause giv	ven in Pert I.	23b. Dld			the cause of death?
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on of Vital	ng Phys fter this ineral di	2	examiner? 1 Yas 2 No 27. Mennar of Deeth 1 Neturai 5 Pending 2 Accident Investigetio	Hospitei: 1 ☐ Inpa 28e. Dete of In (Month, D		ER/Outpatient 28b. Time of injury	28c. Injur Wor	→ □ Ivuraling in		dence 6 Other		v)
Division	To the Hospital or Attending within 24 hours after deeth. To the Funeral Director: After completely filled in by the fune	Certification:	3 Sulcide 6 Could not be determined	286. Plece of I	injury - At ho etc. (Specify	ome, ferm, stre	et, fectory, office		28f. Location (. City or To	Street and Numb wn, State)	er or Rura	l Route Number,
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		-	30. Name and address of person who	completed cause of		23a) (Type, F	Print)	3815		6/29/	199	, 1PZ1740
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al or	5. Social Security Number 229 – 58 – 1024	6. Sax	7. Age (In yrs. 68		If Under Months		f Under 2 Hours	4 Hrs. 8. Min. NO	Date of Birth (Month, De) Vembel	r6,1930	9. Birthp	laca (State or Foreig Stry) ginia
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Director	Maryland W	ashingto	n F	lagers	stown							1 XY 05 2 N
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Ì	15. Deced	dent's Education phest grada completed	d)	16a. Deced	dent's Usua kind of wor DO NOT us	i Occupation	on on most	of working		16b. Kind of B	usiness/In	dustry
Ì	Elementary/Secondary (0-12		(1-4or 5+)		ce Cl					Wholes	sale	Poultry
ŀ	17. Father's Name (First, Midd	fie, Last)		OIII	00 01		8. Mother	r's Name (F	irst, Middle,	Maiden Suman		
	Hubert	Kennedy	Dav	is			My	rtle		Golden		Payne
	19a. Informant's Name/Relation									town, M		
	20a. Method of Disposition	Snook	20b. F	Place of Dispo	_				Date	20c. Location		
	1 X Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other			llsbor				07-0	3-99	Hillsbo	oro,	Virginia
		. 1					\c	cardiac of ri	espiratory ar	rest,		Approximate interval Between Onset and Death
calcal	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. A. G. G. C. C. d. C.	throsol d-stage Due to (o Due to) and io m	utic or as a consec	quence of):	+ D	SK	rse		DISEL	SC	Interval Between
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laian					Certificate	of Deat			3. No.	16	TOUJ		
ysician	1. Decedent's Nan	me (First, Middle, La:	Booth			Date of Death Month June	Day Year		3. Time of Death 7:10 P.M				
/ledical aminer	4a Facility Name	(If not institution, give				4b. City,	Town, or Locatio						
mmer	The second second	Cross Hos		,		Silv.	er Spri				T-17		
al	5. Social Security I		_	ge (In yrs. last b	oirthday) If Under 1	Year If Unde	er 24 Hrs. 8. D	Date of Birth		9. Birthplace (State or Foreign Country)			
	579-76-6	7.77	□M 2120 F	93	Yrs. Months	Days Hours	No.	v. 15,	1905 V		Virginia		
	Usuel Residence of	10b. County		10c. City, Tov	wn or Location					10d. Inside City Limi			
tor					W	ashingt	on, D.	C.		1 A Yes 2 □ No			
Funeral Director	10e. Street and Nu	umber			10f. Zip C	Code	100	10g. Citizen of What Country?					
D	2801 Ne	ew Mexico	Ave. N. V	7.				U. S. A.					
Jers	11. Marital Status		12. Was Deceden		13. Was Decede	nt of Hispanic C	Origin? (Specify	fy Yes or No- 14. Race - American			an Indian,		
	1 Never Mar	rried 2 Married	Armed Forces 1 ☐ Yes 2 🛣			If Yes, specify Cuban, Mexican, Puerto F			Black, White, etc.				
by	3 KWidowed	4 ☐ Divorced	If Yes, Give Year or Dates		1 ☐ Yes 2	X No Specif	fy:	Specify:			hite		
ted	10	15. Decedent's Ed	ducation	166	a. Decedent's Usual	Occupation	act of working	16	6b. Kind of B	usiness/in	dustry		
ple	Elementary/Sec		College (1-4or	5+)	(Give kind of work life. DO NOT use		Jor of Horking			n Hon			
Completed			2		Homema				ne .				
Be ((First, Middle, Last)				18. Mot	ther's Name (Fire	me (First, Middle, Meiden Sumame)					
To	John	Miller					Evelyn	Tyler					
	19a. Informant's N	Name/Relationship (Type, Print)		b. Malling Address (ute Number, (City or Town,	Stete, Zip	Code)		
	Charles	L. Booth,	Jr	Son 2	215 E. 68t	h Stree	t New	York,	New Y	ork	10021		
Department of Health of Important: If Item 27 is any Injury or other tre page.	20a. Method of Disposition 1 XB Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem. 20c. Location - City or Town, State 6/29/99 Arlington, VA												
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons 5130 WI Ave. N. W. Washington, D.C. 20016												
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between		
n ii											Onset and Deeth		
	Immediate Cause disease or conditi- resulting In death)	ion	a. Hypero:	smolar S	State								
	1650iting in coatin	,								1	5 Days		
line				Due to (or es e	e consequence of):						5 Days		
			b	Due to (or es e							5 Days		
хаг	Sequentially list of if any, leading to li	onditions,	b. ————							1	5 Days		
al Examiner	Sequentially list of any, leading to licause. Enter Und Cause (Disease of that interests and the light and the lig	onditions, Immediate Jerlying or Injury	b	Due to (or es e	e consequence of):						5 Days		
Ca	Sequentially list of if any, leading to li- cause. Enter Und Cause (Disease o- that initiated event resulting in death)	IS T	b	Due to (or es e	e consequence of):						5 Days		
ca	that initiated eveni	IS T	b	Due to (or es e	e consequence of):						5 Days		
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State Registrar

31. Date filed (Month, Day, Year)
JUN 2 9 1999

Ram S. Trehan, M. D. 50 W. EDmonston Drive #303 32. Registrar's Signature

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Rockville,

MD

20852

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State of Maryland / Department of Health and Mental Hygiene

					Cel	lincale	OI I	Deam			Reg. h	No.				
	Decedent's Name (First, Middle, Last)								2. Date of Death 3. Time of De					of Death		
ician dical	NAMEH NAIM BABA									JUNE 28, 1999 7:4					P.M.	
niner	4e Facility Name (If not institution, give street and number) 4b.							4b. City, Tov	vn, or Lo	or Location of Death 4c. County of D			of Death			
	HOLY CROSS HOSPITAL							SILVER SPRING			MONTGOMERY					
	5. Social Security Number 6. S 318–50–7525		Sex 1 □ M 2 10 F	7. Age (In yrs. last)		birthday) If Under 1 Yea Months Days		ar If Under 24 Hrs. Hours Min.		8. Dete of Birth (Month, Day, Ye APRIL 11,		Year) 9. Birthr		nplace (State or Foreign LESTINE		
reating and Mental mygene. tem 27 la marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Exercises must be notified at To Be Completed by Funeral Director	Usual Residence of Decedent															
	10a. State MD	ty, Town or Lo	10					City Limits								
	10e. Street and Nur								Citizen of What Country?							
	11435 S	11435 SCHUYKILL ROAD					20852					PALESTINE				
	11. Merital Stetus 1 Never Marri Widowed	ied 2 Married	12. Wes Dece Armed For 1 Yes If Yes, Giv Year or Da		13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes ŽÜNo Specify:					pecify Yes or No- o Rican, etc.) 14. Race Blac Specify			ce - American Indian, ick, White, etc. MIDDLE y: EASTERN			
	(Snec	15. Decedent's E	ducation	ad) 166		16a. Decedent's Usual Occup			of work	ina	16b. Kind of Business/		usiness/In	dustry		
	Elementary/Seco	1	College (1-4or 5+)		(Give kind of work dor life. DO NOT use reti SALES ASS(HECHT COMPANY RETAIL SALES					
	17. Father's Name	18. Mother's Nan					ame (First, Middle, Maiden Surname)									
	SAMAAN	JAMEELAH					АН ВО	BOUTROUS								
	19a. Informent's No	19b. Mailir	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State							State, Zip	Code)					
	HAEL N.	BABA/SO	11435 SCHUYKILL RD. ROCKVILLE						LE,	LE,MD 20852						
or other tra	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State				Place of Disposition (Name of cemetery, crematory or other place)					Date	20c. Location - City or Town, State					
					GATE OF HEAVEN CEMETERY					7/2/99 SILVER S				PRING, MD		
sician edical miner edical	21. Signature of Fu		22. Name and Address of Facility HINES-RINALDI FUNERAL HOME 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD													
	23a, art1. Enter to shock, or hea	he disease, or con in failure. List only	licetions thet co one cause on e	used the dea ach line.									1	Approxime Intervat Bo Onset and	ete etween	
	tmmediate Cause (disease or condition resulting in death)	(Finet on	AR.	ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE								2.50				
	roouting in douting			Due to (or as a consequence of):												
d by the attending physician and etached for use as the burial-transit. Physician/Medical Examiner.	Sequentially list co if any, teeding to in cause. Enter Unde Cause (Disease or	or as a consec	r as a consequence of):								3					
	that initieted events resulting in death)	5	C. Due to (or as a consequence of):													
hysician	Part II. Other signif	licant conditions	contributing to de	ath but not res	sulting in the u	nderlying caus	se giv	ven in Pert I.			1111111111			to the cause	of death?	
0.													24			

been signed by the should be detached has page 2 this 24 hours after death.

Funerel Director: A

Be Completed by

Medicai Certification: To

filled in by

or Attending Physicien: The law requires that the di

To the Hospital

within 2 To the

Division of Vital Records, P.O.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1XXYes 2□ No

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

25. Wes case referred to medical examiner? 27. Manner of Death 1 X Natural

5 Pending investigation 6 Could not be determined

1 ☐ Inpatient 2 🖸 ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 28b. Time of injury

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury st Work? 1 Yes 2 No

26. Place of Death (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

24a. Was an autopsy performed?

29b. Signature

29c. License number D 15236

29d. Date signed (Month, Day, Year) JUNE 28,1999

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

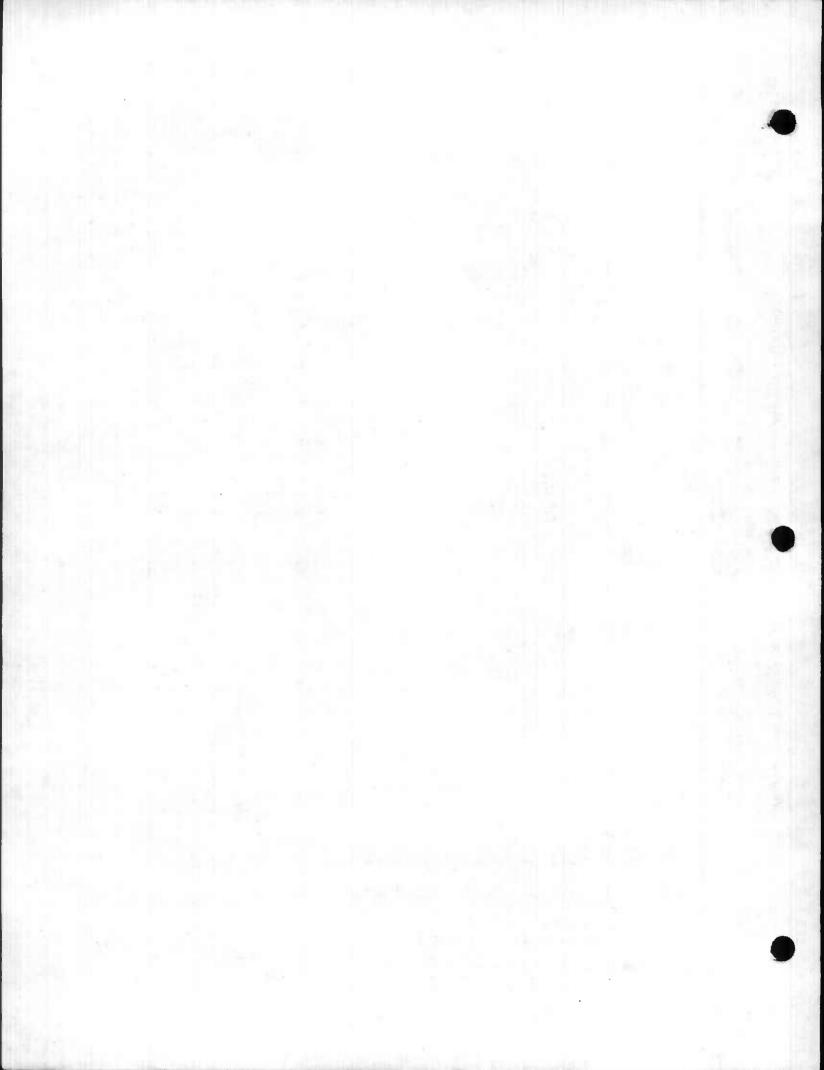
CARL MARGOLIS, M.D.

11125 ROCKVILLE PIKE

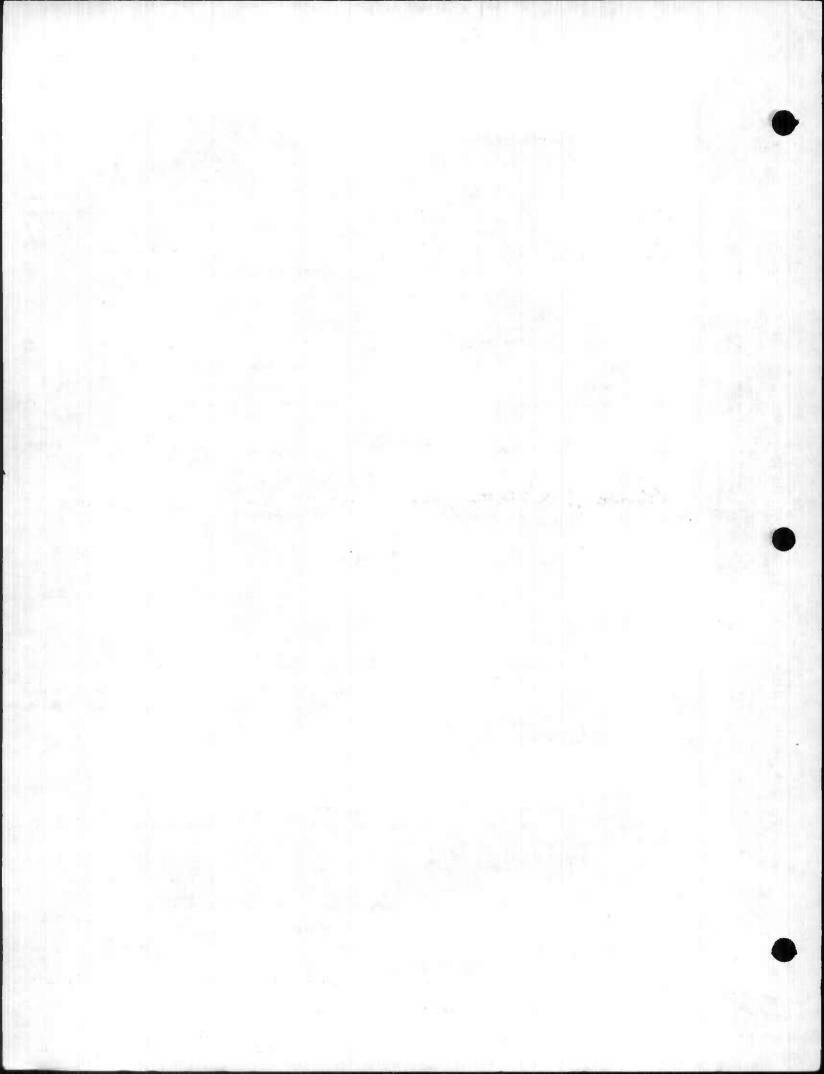
ROCKVILLE, MARYLAND

State Registrar 31. Dete filed (Month, Day, Year) JUL 02

32. Registrar's Signature

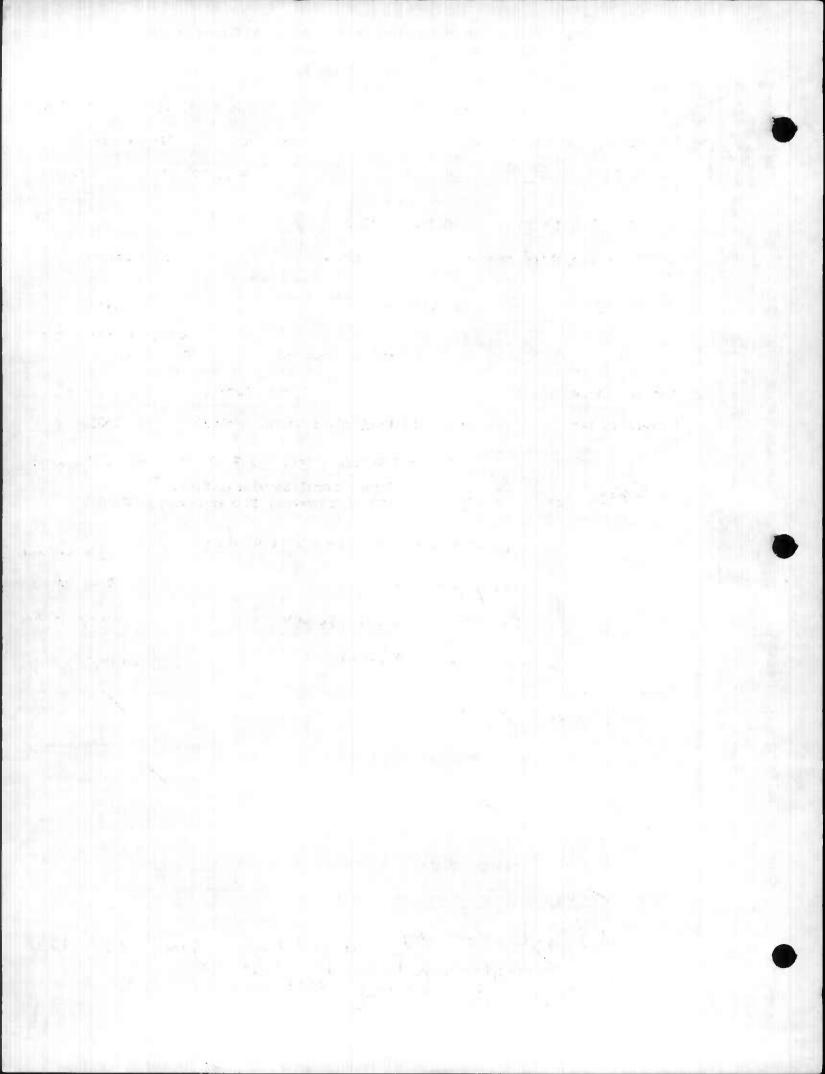


	1. Decedent's Nema (First,	Middle, Last)						Death	2. Date of De			3. Time of E	Death
Physician /Medical	PHILIP	MEYE	R	BAKEI	}				JUNE 2	23, Tay	Year	9:4.	5 PM
xaminer	4a Facility Neme (If not ins			ber)			.4	b. City, Town, or I			ty of Death		
	5555 FRIE			A 76	form for the day of	If Under 1 Y	001	CHEVY (_		NTGOM		-
eral etor	5. Social Security Number 577–36–3089 Usuel Residence of Decede		M 2 F	89	last birthday) Yrs.		ays	Hours Min.	8. Dete of Bi (Mogth, Di NOV	12, 190	9 WA	place (State or SHINGTO	N,DC
Funeral Director	10a. Stete 10b. C			10c. Ci	ty, Town or Lo	cation					1	10d. Inside City	Limits
tor	MARYLAND MC	NTGOME	RY		CHEVY	CHASE						1 🖾 Yes	2 □ No
al Director	10e. Street and Number 5555 FRIEN	DSHIP	BLVD.			10f. Zip Co	de	20815		10g. Citizen o			
by Funeral	11. Marifal Status 1 Never Merried 2 3 🖾 Widowed 4 Div] Merried	2. Was Deced Armed For 1 Tes : If Yes, Give Yaar or Da	ces? 2 (XINo		Wes Decedent f Yes, specify 1 ☐ Yes 2 ☑		ispanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No Rican, etc.)	Spec	ace - Americ ack, White, ify:		
Completed		cedent's Educ			(Give	dent's Usuat O	one o	turing most of wor	king	16b. Kind of	Business/In	dustry	
idm	Elementery/Secondery (0		College (1-	4or 5+)	LAWY	DO NOT use re	etired	7		LEGAL			
ő	17. Fether's Neme (First, M	iddle, Last)	, ,		LAWI	LLIC	Т	18. Mother's Nan	ne (First, Middle		ime)		
o Be	NATHAN BAK	ER						YET	TA LOEI	3			
-	19a. Informant's Neme/Rel	etionship (Typ	e, Print)					and Number or Ru					
	BOBBY L. F	AKER	(SON					ROAD -					
	20a. Method of Disposition 1		emoval from S		cemetery, cren	sition (Name of netory or other D MEMO	pleo	AL GARD	Dete 6/27/9	20c. Location FALL		RCH, VA	•
	21. Signature of Funeral Se	rvice License	Ŷ		22 E	. Name and A DWARD	ddres SAC	ss of Facility GEL FUNE	RAL DIRE	ECTION,	INC.		
	Conald	CX	Ttota	temej	er I	091 RO	CK	VILLE PIR	CE - ROC	CKVILLE	, MD.		
	23a. Pert1. Enter the disea shock, or heart feilure	. List only one	etions that ca couse on ea	ch line	th. Do not ent	er the mode of	dyin	g, such es cardiac	or respiratory a	arrast,		Approximate Interval Betwonset and Description	een eath
	fmmediata Cause (Final			AT THE	TMEDC T	TCEACE					1	YEARS	
Н	disease or condition resulting in death)	a.			Dras a consec	DISEASE	1				1	ILAKS	
iner						,							
dicai Examiner	Sequentially list conditions if any, leeding to immediate cause. Entar Underlying Cause (Disease or injury			Due to (or es a conseq	juence of):					-		
-	that initieted events resulting In death) Last	1		Dua to (d	or es a conseq	uence of):					1		
Physician/M		d.									1		
/sici	Pert ii. Other significant co	nditions cont	ributing to dea	th but not res	ulting in the u	nderlying caus	e give	en in Pert f.	23b. Did	tobacco use d	contribute t	o the cause of	death?
by Phy									1	Yaa 2 🔯 No	3 ☐ Pro	obably 4 U	Inknown
Completed										an autopsy ormed?	an Cr	ere autopsy fir vailable prior to empletion of ca death?	
mo.									10	Yes 2 No	1	□Yes 2□ N	4o
e e	25. Was case referred to m	-						26. Place of Dea	th (Check only	one)			
70	1 Yes 2 No	Ho	ospitel: 1 ☐ In 28a. Date of	77	ER/Outpatien		Othe	4 LI Norsing n	ome 5 N Res			rly)	
cation	1 XNaturel 5 F	Pending nvestigation Could not be	(Month	Day Year)	28b. Time of tnjury	M 28c.		k? Yes 2 □ No		how injury occ			
Certification:		etermined	28e. Place of building	of Injury - At h g, etc. (Speci	ome, ferm, str	eet, fectory, of	TiC8			(Street end Nur own, State)	n <i>per or</i> Rur	ai Houte Numb	er,
edical				ils of examine				ne, date and place pinion, death occu					
Medical Certification	29b. Signatura and fitla of o	ertifiar				29c. Li	cense	e number		29d. Date sign			
	Aur	D31 =1	-N	ne	5	D39	45	6		JUNE 24	, 199	9	
	30. Name and address of po						EN	UE, #930	- CHEV	Y CHASE	, MAR	YLAND 2	20815
- 1													

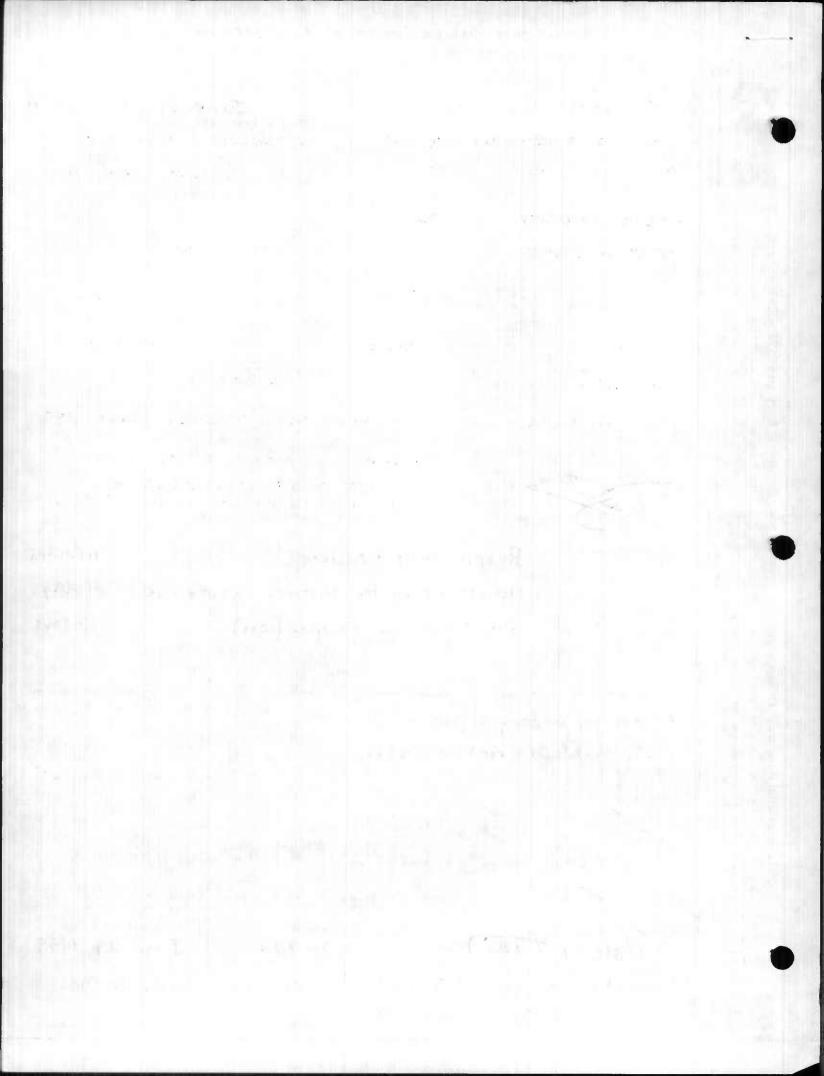


State of Maryland / Department of Health and Mental Hygiene

						, and y land		tificate of	Death	Re	g. No.	-	1000	
		_	1. Decedant's Nama (First, Mic	ddla, La	st)					2. Data of Death Month	Day	Yaar	3. Tima of Death)
	Physician				Melvin	E. B	a11			June 27		Tatali	2:45 AM	
	/Medica Examine	_	4a Facility Name (If not institu	tion, giv					4b. City, Town, or L		4c. County	of Death		
(3)	L.Adiiiiiici	1	Washington A	dve	ntist Hos	pital			Takoma P	ark	Monts	gomer	у	
1	Funeral		5. Social Sacurity Number	6. 5		Age (In yrs. la	st birthday)	If Under 1 Year		8. Date of Birth (Month, Day,	Vacal	9. Birthp	lace (Stata or Fore	eign .
L	Director	-	225-24-3506 Usual Rasidance of Dacedant	1	XM 2□F	77	Yrs.	Months Days	Hours Min.	Nov. 29,		West	Virginia	1
	show		10a. State 10b. Cour	nty		10c. City,	Town or Loc	cation				1	0d. Inside City Lim	iits
	Men de la	ğ	Maryland Mor	ton	mery	S11	ver S	nrino					1 □ Yas 2 💢	No
	or 28a-f s	5	10e. Street and Number					10f. Zip Code		10	g. Citizen of V	What Cour	ntry?	
	Sa C		12325 New Ham	nsh	ire Avenu	10		20904		1	United	Stat	es	
	ours effer death with the Meryla all, or Herns 23a or 28a-f show Examiner must be notified at but Elineral Disagrap	e -	11. Marital Status	pon	12. Was Decedar	nt Evar in U,S	. 13. V	Vas Decedent of I	Hispanic Origin? (Sp	ecify Yas or No-	14. Rac	e - Americ	an Indian,	-
0	flor	בֿ	1 Never Married 2 M	larried	Armed Forces 1 N Yes 2 If Yes, Giva				oan, Maxican, Puerto	Hican, etc.)	151101	sk, Whita,	etc.	
050	urs e	2	3 ☐ Widowed 4 ☐ Divord	ed	If Yes, Giva Year or Dates	: Unava	ilable	☐ Yes 2 X No	Specify:		Specify		ite	
5-0020		2	15. Deced	lent'a Ed	ducation	1	16a. Deced	ant's Usual Occup	pation during most of work	1	6b. Kind of Bu	usiness/in	dustry	
21	hin 7		(Specify only hig Elementary/Secondary (0-12	- 1	Collega (1-40	or 5+)	lifa. E	O NOT usa ratire	ed)	N	ationa	1 Ins	stitutes	
2121	offied within all Hygiene.	5	12				Mecha	nical En	gineer	0	f Heal	th		
pu	be filed tal Hygi d other event, the		17. Father's Name (First, Midd	la, Last,					18. Mother'a Nam	a (First, Middla, M	aiden Suman	na)		
/Jai	merked o	0	George Irvin	ng	Ball				Lydia	Hutzell				
Maryland	d 2 should be filed within 72 hr in and Mental Hygiene. 7 ie merked other than "natus traumetic event, tra Medical To Be Commissed		19a. informant's Name/Ralatio	onship (Type, Print)		19b. Mailin	g Addrass (Street	t and Number or Rui	ral Routa Number,	City or Town,	Stata, Zip	Code)	
-	C = 0 -		Suzanne C. Lo	rd	(guaro	dian)	401 H	ungerfor	d Drive,	Rockvill	e, MD	208	350	
ore	of Heal		20a. Method of Disposition		Dament from Chair	COL	natary, cran	sition (Nama of natory or other pla	ice)	Data 2	0c. Location -	City or To	wn, State	
Baltimore			1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other				land	Veterans	Cem. 7	-7-99 C	helten	ham,	Maryland	
alti	permit. Pag Department important: I eny Injury o		21. Signature of Funeral Servi	ce Licer	1590		22	Name and Addra	ass of Facility				d	
m	Depa impo eny l		leen	Q	. Kas	20			ral Servi			WD 20	010	
		+	23a. Part1. Enter the disease,	or com	plications that caus	sed tha daath.			Avenue, S ing, such as cardiac			'ID 20	Approximate	
4	Physician	1	shock, or heart failure. L	ist only			0			1.		1	interval Between Onsat and Death	
	/Medical		immediata Causa (Finai		ven	thic	uku	1 Tu	chyc4	ruch		3	o min	ut.
	Examiner		disease or condition resulting in death)		a	Due to for	as a _s conseq	uanca oft				1	1	
	<u> </u>	ē l			HV		X1 a	derice or).				ar	re dry	/
	icata be asscuted physician and s the burial-transit		Coquentially list conditions		b	Due to (or	as a conseq	uence of):				1	,	
ó	axed axed in an inal-tr		Sequentially list conditions, if any, laading to immediate cause. Entar Underlying Cause (Disease or injury		Cevi	eri		phy se	LMY			MIN	~y Yea	1
68760,	tificata be axeculg physician and as the burial-trai	200	that initiated events	5	C	Due to (or a	as a consequ						, ,	
	50 D. 40		resulting in death) Last	ш	MICO	T	A	buse				4 4 74 14	y Yeur	-1
Box	andin usa	N A			d. MTCO	(110 (,			4	Mai	7 7 84:	_
	The law requires that the death certilate has been signed by the attending page 2 should be detached for use a	2	Part II. Other significant cond	itions c	ontributing to death	but not result	ting In the ur	iderlying cause gi	ivan In Part i.	23b. Did tot	acco use co	ntribute4	o the cause of dea	ath?
P.0	by the	2									8 2□ No		bably 4 ☐ Unkn	
	ned e de	7	Congest	IVE	4-6,	~ / /		ai liu						
Records,			J							24a. Was an		24b. W	era sutopsy finding ailable prior to	gs
8		le l								perform	ed r	co	mpletion of cause death?	
Re	The law requires at the law requires at the law requires a should be a should									1 □ Ye	s 2P No		□Yas 2□ No	
B	certificate has rector, page 2		25. Was case referred to medi	ical					no Place of Day				1188 20140	
5	Attending Physician: ordesth. octor: After this certific by the funeral director,	0	axaminer?	iCall .	Hospital:	*i 205	D/O	Ot DOA Ot	hor:	th <i>(Check only</i> onsome 5 ☐ Rasidad		(Casa)	4.)	
of	Physic chis corral dire		27. Manger of Death		28a. Date of in		R/Outpatien 28b. Tima of			28d. Describe ho			γ)	
on	ding h. After fune	2	1 Naturai 5 ☐ Pen	ding stigation	28a. Date of in (Month, L	Day Year)	injury		ork?]Yes 2 □ No					
5	daat daat ctor: y tha	2	3 ☐ Sulcide 6 ☐ Cou	ld not b	e one Diese - 61	iniury - At hon	na farm stre	eat, factory, office		28f. Location (Str	eet and Numb	ber or Run	al Routa Number,	
Division of Vital	or A after Direction of In Direction		4 Homicida	armined		atc. (Specify)		,		City or Town,	Stata)			
	pours ours filled	2	29a. Certifier 17 Certif	vina Ph	velcian: To the has	st of my knowl	ledge death	occurred at the ti	ime, date and place,	and due to the ce	usa(s) and m	annar as s	stated	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page Madical Certification: To Re Com	3	(Check only 2 Medic	al Exam	niner: On the basis	of examination	on and/or Inv	estigation, in my	opinion, daath occur	rad at tha tima, da	te and piace,	and due t	o the cause(s)	
	ithin o the omple		29b. Signature and title of cent	ifier		4		29c. Lican	se number	29	d. Data signe	d (Month,	Day, Year)	
			Rushid	13	yL ~		MD	N 3	9372		ine	28	1	9
	5	-	*							(2)		-0	(///	
			30. Name and addrass of pers	on who	completed cause of	death (item)	zaa) (Dipe,			7 526	4 31	D		
			31. Date filed (Month, Day, Ye	AAI AAI	32 Pools	strar's Signatu	209	01	Rashid Bag	gnai-Nain	1, M.	υ.		
	State Registrar		JUN 3 0		11	acres signatu	6	Some &	11					
			00110	- IJ			1	107500	2					

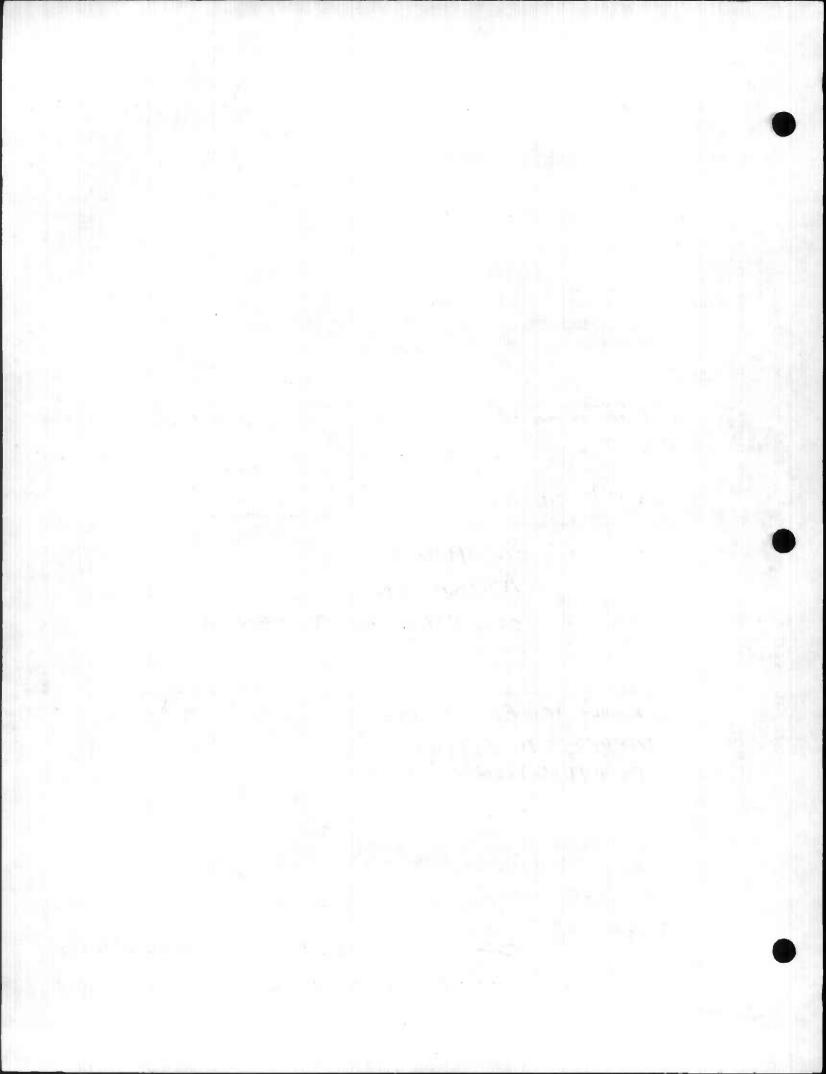


Amend #7,	State of Maryland / Department of Health and 6/30/99, JW, Montg. County Certificate of Death		ene	21989
Observator	1. Decedent's Neme (First, Middle, Last)	2. Dete of Deeth Month	Dev Y	3. Time of Deeth
Physician /Medical	Barnett Bauman	June	29 199	19 1055 A
Examiner	4a Facility Neme (If not institution, give street end number) 4b. City, Town, or	Location of Deeth	4c. County of	Deeth
	Shady Grove Adventist Hospital Rockvi	lle, MD	Montg	omery
Funeral Director	5. Sociel Security Number 099.10.7168 6. Sex 12 M 2 F 7. Age (In yrs. lest birthday) 15 Under 1 Yeer 16 Under 24 Hrs Months Deys Hours Min.		(ear) 03 1	Birthplece (State or Foreign Country) NEW YORK
9 >	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			40d Incide City Limite
the Maryland r28a-1 show rottled at	MARYLAND MONTGOMERY ROCKVILLE			10d. Inside City Limits 1 Yes 2 □ No
E 0 E	10a. Street and Number 1508 COLUMBIA AVENUE 10f. Zip Code 2085). Citizen <i>o</i> f Who SA	at Country?
dead dead	11. Meritel Stetus 1 □ Never Merried 2 □ Married 1 □ Never Merried 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Ves 2 □ No WW III 13. Wes Decedent of Hispenic Origin? (S it Yes, specify Cuben, Mexican, Puer III → Yes, Give Yeer or Detes:	Specify Yes or No- to Rican, etc.)	Bleck,	American Indien, White, etc. WHITE
d 21215-0020 filed within 72 hours stear hygiens. they han "natural", or he ent, the Modreal Examines et Completed by Fu	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 16e. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) PLUMBER	nking	Sb. Kind of Busin	
B edaby B	17. Father's Neme (First, Middle, Last) MORRIS BAUMAN 18. Mother's Neme (SADIE W	me (First, Middle, Ma VALLOWITZ	aiden Sumeme)	
C = N L	19e. Informent's Neme/Reletionship (Type, Print) WENDY JARMUTH/DAUGHTER 19b. Mailing Address (Street and Number or Reletionship (Type, Print)) 19c. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Reletionship (Type, Print))			
0 % 5 1 2	20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) JUDEAN MEMORIAL GARDENS			ty or Town, State ARYLAND
Baltimore Page Departing Page Department Important in Important in Page Department Important in Page Department Important in Page Department Important in Page Department Important in Page Department Important in Page Department Important in Page Department Important	21. Signature of Funeral Service I censee 22. Name and Address of Fecility EDWARD SAGEL FUNE 1091 ROCKVILLE PIE 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardle shock, or heart tailure. List only one cause on each line.	ERAL DIREC	TION, I	NC.
/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death) e. Respiratory Failure Due to (or as a consequence ot):			minutes
60, be executed ician and burial-transit	Sequentielly list conditions, Due to (or es e consequence of)!	Syndra	me	9 days
6876(licata be physicia s the bur	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet Inlitieted events resulting in death) Lest Due to (or es e Lonsequence of): Due to (or es e consequence of):	n)		16 days
Box 6 sath certific attending p for use as	d			
P.O. at the d by the deby the detached Physic	Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. Covenary avtery disease			ibute to the causs of death? Probably 4 Unknown
Division of Vital Records, or Attending Physician: The law requires the after death. The law requires the after death is certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by entification: To Be Completed by	peripheral arterial disease	24e. Wes en performe		24b. Were eutopsy tindings eveilable prior to completion of cause of deeth?
The law ata has page 2		1 ☐ Yes	2 No	1 □ Yes 2 DNo
Vital Fidelan: The certificate rector, pag	25. Wes case referred to medical 26. Piece of De	eth (Check only one)		
of Vital hysician: his certifica il director, I	exeminer? Haggital: Other:	Home 5 ☐ Residen		(Specify)
vision of Vita Attending Physician: r death. r death. r death. by the funeral director, by the funeral director.	27. Manne-of Deeth 1 Neturel 5 Pending (Month, Day Yeer) 28b. Date of Injury (Month, Day Yeer) 28b. Time of Injury Work? 1 Yes 2 No	28d. Describe how		
Division c tall or Attending P as after death. al Director: After to led in by the funera Certification:	3 ☐ Suicide 4 ☐ Homlcide 6 ☐ Could not be determined 28e. Plece of Injury - At home, term, street, tactory, office building, etc. (Specify)	28t. Location (Stre City or Town,		or Rurel Route Number,
Hospi 14 hou Funer tely fill	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plectory one and menner steted.			
To the complex complex Med	29b. Signeture end title of certifier Noleet HW D 24773		d. Dete signed (Tune	Month, Day, Year) 29, 1999
	30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) Robert L. Fox MD 9715 Medical Center Di			
State	31. Dete tiled (Month, Dey, Year) 32. Registrar's Signeture			



State of Maryland / Department of Health and Mental Hygiene

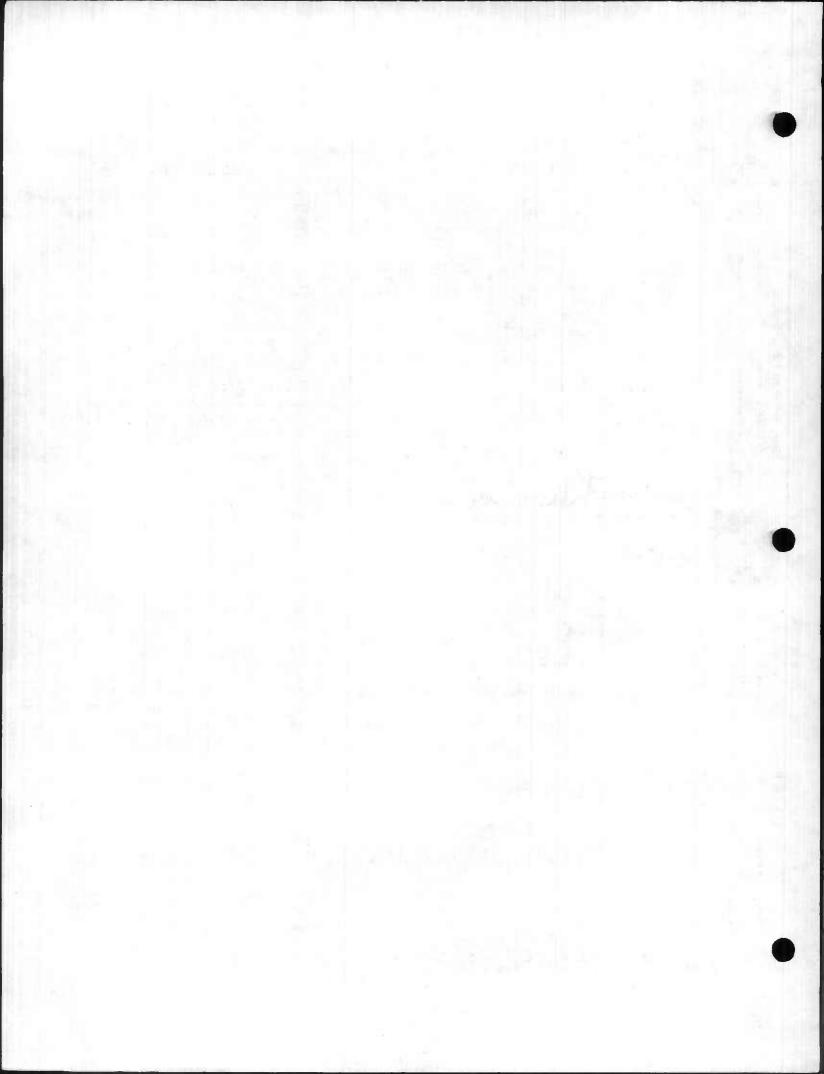
		Otate of Marylar		e of Death	R	eg. No.	2 2 1	220
Physician	Decedent's Neme (First, Middle, La		400		2. Date of Dea Month	Day	Year	me of Deeth
/Medical	Walter	George	Behr			5, 199		:45P.
Examiner	4a Facility Name (If not institution, given Hillhaven Nur	•		Adelp	Location of Death hi	4c. County Pri	nce Geo	orge's
Funeral Director	214-12-7796	Sex 7. Age (In yrs.	90 Yrs. If Under Months	1 Year If Under 24 Hrs Days Hours Min	8. Date of Birth (Month, Day OCt • 22	1908	9. Birthplace (S Country) Washingt	
pun a	Usual Residence of Decedent 10e. State 10b. County	10c. C	ity, Town or Location				10d. Ins	ide City Limits
e Maryt la-f sho tifisd a	Maryland Prince	George's Co	ollege Park		- 19			Yes 2□No
death with the Maryland ms 23s or 28s-f show canal be notified at neral Director	10e. Street and Number 4706 Tecumseh St	reet)740	1	og. Citizen of V United	What Country? States	
- 2 2 5 D	11. Maritel Stalus 1 Never Married 2 Memed 3XXVidowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1X Ves 2 No If Yes, Give Year or Dates: 1926	J.S. 13. Was Dece If Yes, spe 5–1929 1 ☐ Yes	dent of Hispanic Origin? (Scity Cuban, Mexican, Puer 2) No Specity:	Specify Yes or No- to Rican, etc.)		e - American Indi sk, White, etc. :: White	
21215-0 ed within 72 ho vojevna. er than "natura f. the Medical. Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Decedent's Use (Give kind of wo	al Occupation rk done during most of wo se retired)	orking	16b. Kind of Bu	usiness/Industry	0.46
mpi mpi	Elementary/Secondary_(0-12)	College (1-4or 5+)	Carpente		The Late	Private	e	
Maryland 21215-0020 62 should be filed within 72 hours at h and Merital Hygiena. 7 is marked other than "natural", or trearmetic event, the Medical Exam To Be Completed by i	17. Father's Name (First, Middle, Last			18. Mother's Na	me (First, Middle,			
Vial Menta M	William Frederic	K Behrens, Sr.	•	Sarah	Bewley			
4 2 8 8 2	19a. Informant's Neme/Relationship (Kenneth G, Behr	ens (son)	161 McGui	(Street and Number or Rice Road Winc				
Baltimore semil, Pages 1 Separiment of Hs mportant, if then my injury or oth blids.	20a. Method of Disposition XXBurial 2 Cremation 3 E 4 Donation 5 Other (Specif	Removel from State	Place of Disposition (Na cometary, crematory or Orge Washin	ne of other place) yton Cemeter			City or Town, St 1phi, Mar	
Balt pemit, Ospartrimporta	21. Signature of Funegal Service Lice	DON 12101+	22. Name e Dona10 4400 1	d Address of Facility V. Borgward Powder Mill	dt Funera Rd. Belts	1 Home,	P.A. Marylan	d 20705
	23a. Part1. Enler the disease, or shock, or heart failura. List only	phranons that caused the dea					Appro	ximate el Between
Physician /Medical Examiner	Immediata Cause (Final disease or condition resulting in death)	U	or as a consequence of) ATTON.					
6876(ficeta be physicia s the bur	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. OLD 5	or as a consequence of) TROKE AA or as e consequence of):	DEME	ENTIA	4		
the d	Part II. Other significant conditions of			ausa given in Part I.	23b. Did to	1	ntribute to the c	
of VItal Records, Physician: The law requires that this certificate has been signed by rail director, page 2 should be detailed to Be Completed by Pl	DIABETES DE HYDI	MELLIT	us		24a. Wes e perfor		24b. Wera aut avsilable completio of deeth?	prior to on of cause
The law ate has page 2	DE HYDI	CATION			10 Y	as ZXNo	1 🗆 Yas	2 XX No
r VItal I yelclan: The s certificate director, pag	25. Was casa refarred to medical axaminer?				ath (Check only or	na)		
Or VITA Phyalclan: this certific ral director,	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2			Home 5 Resid			11751
DIVISION (Let or Attending P Re after deeth. I Director: After to I of in by the funent Certification:	27. Manner of Death Value 5 Pending investigation		28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe h			
DIVISION all or Attending a ster deeth. I Director: After od in by the fune	3 Suicide 6 Could not b 4 Homicide detarmined	28e. Place of Injury - At h building, etc. (Speci		y, office	28f. Location (S City or Tow	treet and Numb n, State)	per or Rural Rout	e Number,
DIVISION O To the Hoapital or Attending Ph within 24 hours affer deeth. To the Funeral Director: Affer th completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) Certifying Ph	nysician: To the best of my known on the basis of examination manner stated.	owledge, deeth occurred ation and/or investigation	at the tima, data end place, in my opinion, death occ	e, and due to the c urred at the time, c	ause(s) and ma lata and piece,	annar as stated. and dua to the co	ause(s)
To the within	29b, Signature and title of certifier	Land;		22910			d (Month, Day, Y	
	30. Nama and address of person who Asif S. Qadri,		m 23a) (Type, Print)					
State	31. Dete filed (Month, Day, Year)	32. Registrar'e Signi	ature		riege rai	K, Mai	Tallu ZU	740
Registrar	JUN 3 0 1	999 Benev	~ B.	sould				



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE 25, **Physician** 7:15 AM BERTHA BLOCK BLAUNER /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REBECCA HOUSE POTOMAC MONTGOMERY 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JULY 31, 1909 Birthplace (State or Foreign Country)
 MARYLAND **Funeral** Days 1 ☐ M 2 ☐ F Months Hours 577-07-6874 89 Director Usual Residence of Decedent death with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show ne 23a or 28a-f short MARYLAND MONTGOMERY POTOMAC 1 No Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9910 RIVER ROAD 20854 UNITED STATES Funeral Heme Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after ☐ Yes 2 X No Yes, Give 1 Never Married 2 Merried 21215-0020 ò 1 ☐ Yes 2 ♥ No Specify: Specify: þ 3 XWidowed 4 ☐ Divorced WHITE Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fit ment of Health and Mental Hant: If Item 27 is marked oth lury or other treumstic even Be SAMUEL SILVER ESTHER LEVITT 19e. Informent's Neme/Retationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARILYN R. BLOCK (DAUG.-IN-LAW) 20 BEMAN WOODS COURT - POTOMAC, MARYLAND 20854 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20s. Method of Disposition Date 20c. Location - City or Town, State 12 Burial 2 Cremation A Removal from State Department of Important: If any injury or 4 □ Donation 5 □ Other (\$ KING DAVID MEM. GDN. 6/27/99 city) FALLS CHURCH, VIRGINIA 21. Signiffure of Funefal Service Licensee 22. Neme and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, on heart faiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Cause (Final ALZHEIMERS DISEASE diseese or condition resulting in death) Examiner Due to (or as a consequence of): Examiner The law requires that the deeth certificate be executed buriai-transit Sequentielly list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical the Due to (or es a consequence of): USB as Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? ned by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ ate has been signe page 2 should be 24b. Were autopsy findings available prior to Be Completed 24a. Was an autopsy completion of cause of death? certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: director. 25. Was case referred to medical 26. Place of Deeth (Check only one) ASSISTED Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this funerai 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Neturet 5 Pending Investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Medical 29e. Certifier completely To the Vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JUNE 25, 1999 D31319 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LORETO ALBIOL - 8218 WISCONSIN AVENUE #103 - BETHESDA, MARYLAND 20814 31. Dete filed (Month, Day, Year) 32. Pegistrer's Signeture State JUN 2 9 1999 sacks Registrar



	1. Decedent's Name (First, Middle, Last)						lealth and I Death		Reg. No.		3. Time of Deeth
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by Funeral	11. Marital Status 1 Never Merried 2 Ma 3 XWidowed 4 Divorce	rried 1 🔼 Yes			Was Decedo If Yes, speci 1 ☐ Yes 2		lispanic Origin? (S an, Mexicen, Puerl Specify:	pecify Yes or No to Ricen, etc.)	acify Yes or No- Ricen, etc.) 14. Race - American India Bleck, Whita, etc. Specify: WHITE		
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n/Medical Examiner	disease or condition resulting In deeth) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest	eC(Due to (quence of):	LURF	3				3 YEARS
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29c. License number

D09577

29d. Date signed (Month, Dey, Year)
JUNE 28, 1999

State Registrar 29b. Signatury ar

RICHARD H. POLLEN, MD - 10400 CONNECTICUT AVENUE # 606-KENSINGTON, MD. 20895

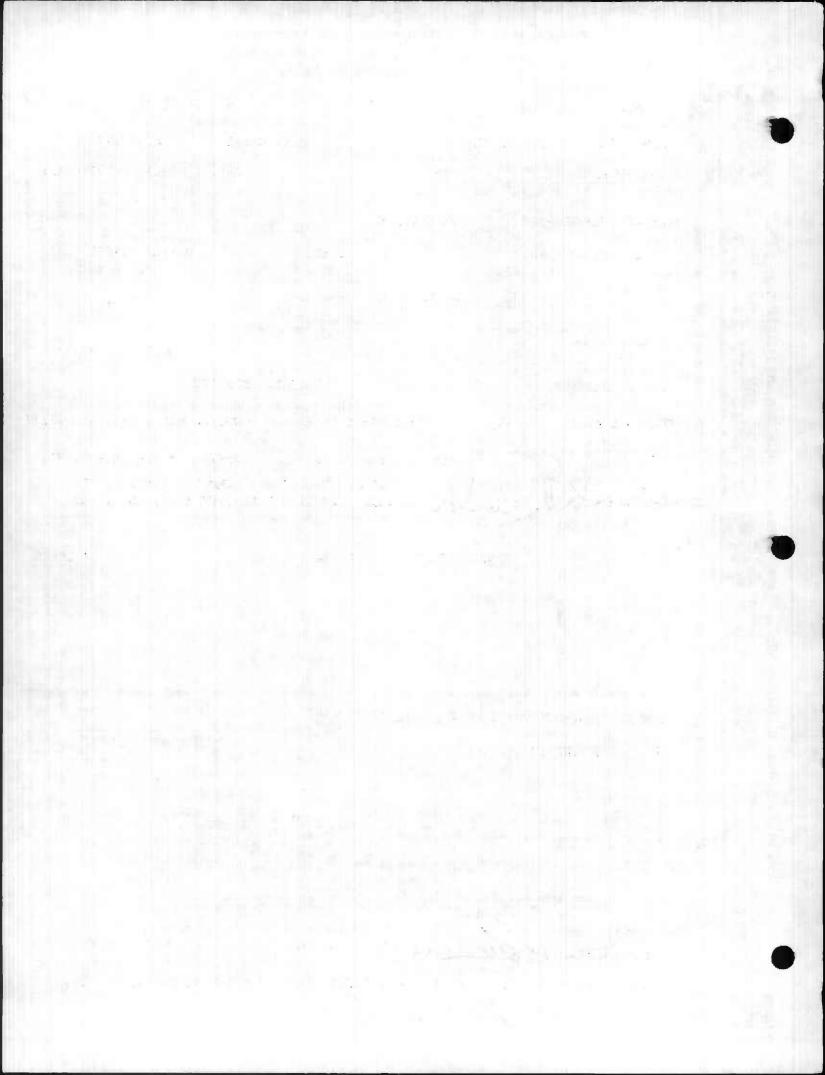
31. Dete filed (Month, Day, Year)

JUN 2 9 1999

32. Segistrer's Signeture

J. Sports

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print)



P.O. Box 68760, Records, of Vital or Attending Physician: Division To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A

Other:

Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Menner of Deeth Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1- Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature end title of certifier

State Registrar

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31. Date filed (Month, Day, Year) JUN 2 9 1999

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

SAMEH ALY 48IN Frederick Ave. #230 Garthersburg 32. Registrer's Signature

29c. License number

B4584-3

29d. Date signed (Month, Day, Year)

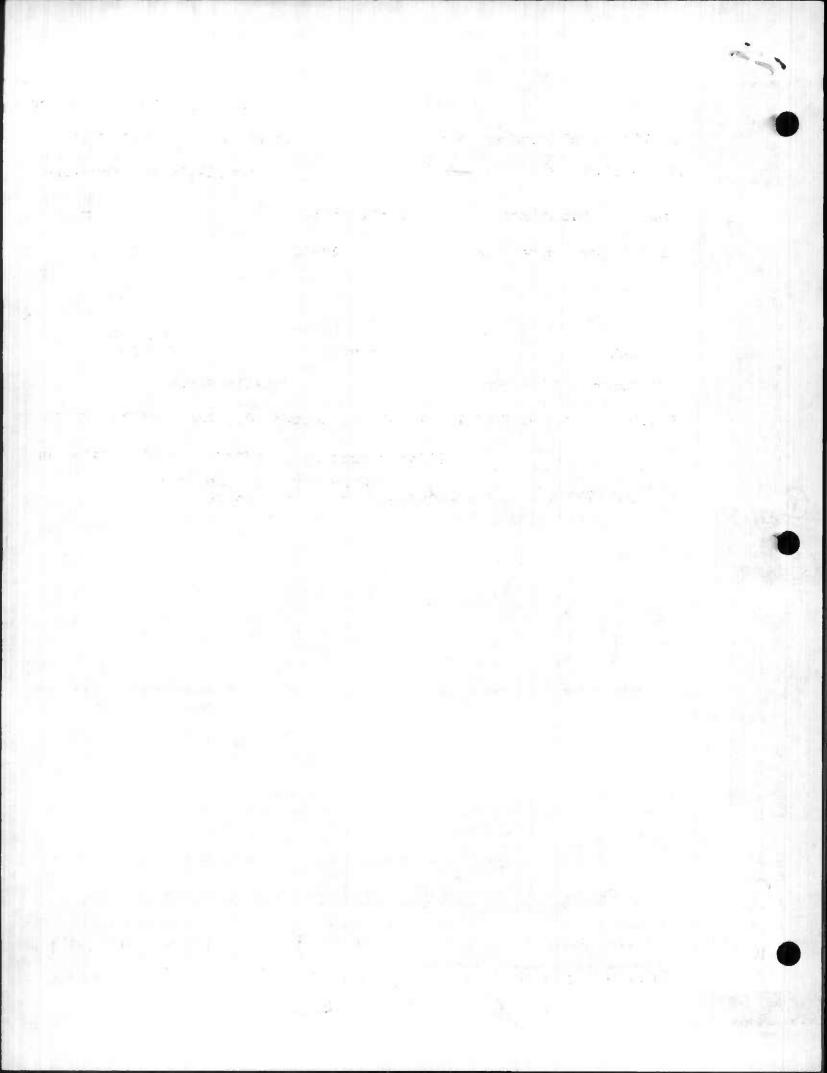
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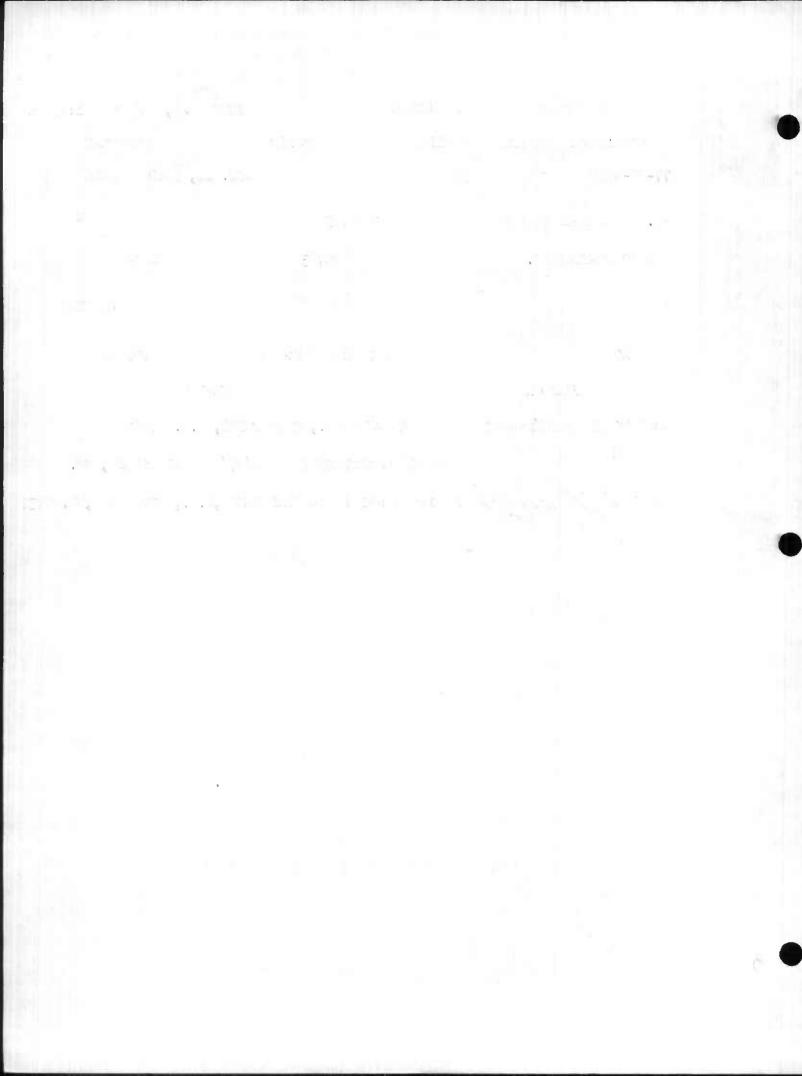
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

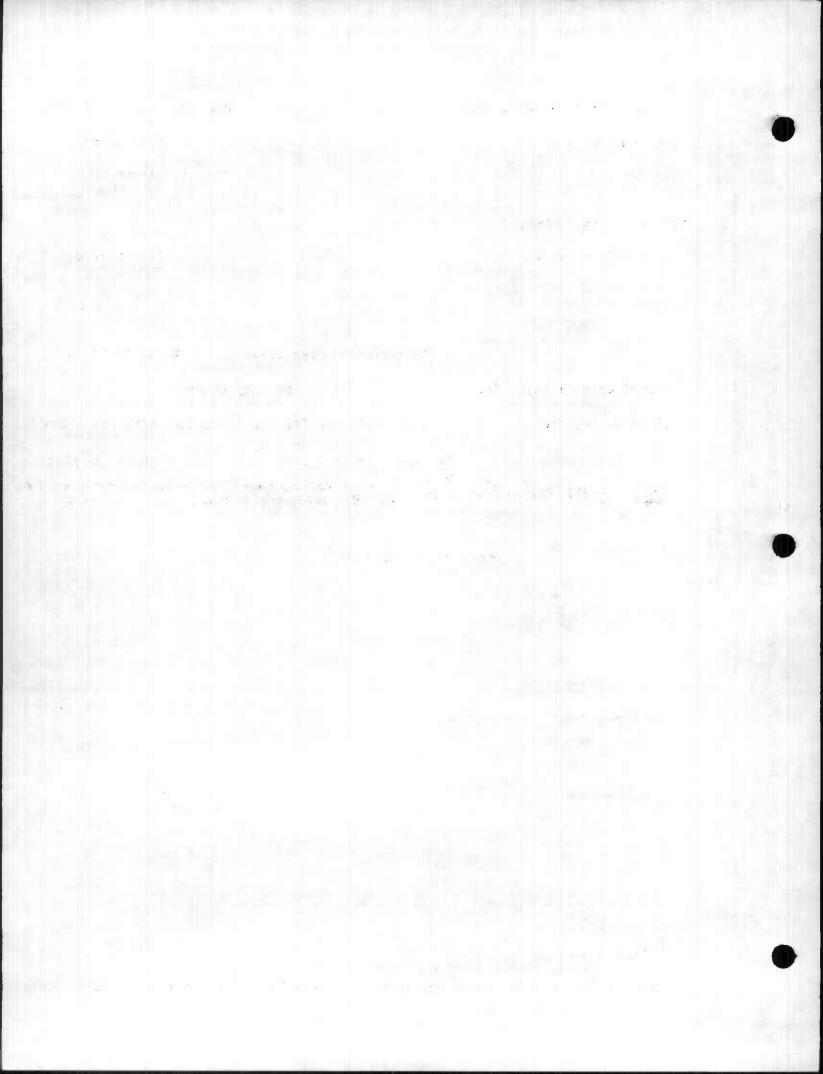
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State of Maryland / Department of Health and Mental Hygiene

			Certificate of	Death	Reg. f	No.		
Physician	Decedent's Nama (First, Middle, Last)				2. Date of Death Month	Day Yaar	3. Time of Death	
/Medica	Samuel Carroll Boyd				June 29,		2:30AM	
Examine	4a Facility Name (If not institution, give street en	d number)		4b. Cify, Town, or Loc	cation of Death	4c. County of Deat	h	
	9634 Culver Street			Kensingt		Montgomery		
Funeral	5. Social Security Number 8. Sex	7. Age (In yrs. last bit	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, Yea	9. Birt	hplece (State or Foreign untry)	
Director	577-03-4736	83	Yrs.		February 8,	1916 Wash	nington, Do	
pu »	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits	
ehon eho		Too. Only, Tow	TO LOCATION				1 ☐ Yes 2 🕅 No	
or 28a-f el	Maryland Montgomery	Kens	ington					
or 2	10e. Street and Number		10f. Zip Coda		10g. 0	Citizen of What Co	untry?	
23a	9634 Culver Street			895		nited St		
r items 23 officer mark	11. Marital Status 12. Was Arme	Dacedant Evar In U,S. d Forcas?	13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spe an, Maxicen, Puerto I	cify Yas or No- Rican, atc.)	14. Raca - Ame Black, White		
0 0 9	H Vot	/es 2□Norld	1 ☐ Yes 2 X No	Specify:		Specify:		
"natural", o	3 Widowed 4 Divorcad Year	or Dates: War II				WI	nite	
ed within 72 hoi ygjene. or than "natura t, tra Medical I	15. Decedent's Education (Specify only highest grade comple	ted) 16a	Give kind of work done	during most of working	16b.	Kind of Business/	Industry	
	Elementary/Secondary (0-12) Colle	ge (1-4or 5+)	life. DO NOT use retire					
e filed within at Hygiene. other than vent, the M		Со	nstruction :			lectric	Company	
tai Hyg d othe event,	17. Fether's Neme (First, Middle, Last)			18. Mother's Name	(First, Middle, Maid	eri Sumame)		
d 2 should be file th and Mentai Hy 7 is marked othe traumatic event					y Benson			
d 2 should th and Mer 7 is marks traumatic	19e. Informent's Name/Reletionship (Type, Print,	198	. Mailing Address (Street	end Number or Rura	l Route Number, Cit	y or Town, State, 2	(ip Code)	
C - OI L	William C. Boyd/son	18	12 North Ode	e Street,				
oemit. Pages 1 an Department of Heali mportant: If item 2 any Injury or other ance.	20a. Method of Disposition 1 Burial 2 □ Cramation 3 □ Removal f	20b. Placa o cemete	f Disposition (Neme of ry, cremetory or other ple	∞ July 2.	1999 20c.	Location - City or	Town, State	
Pages net of i	4 Donation 5 Other (Specify)		awn Memoria	_	Ro	ckville.	Maryland	
permit. Pa Departmen Important: any Injury	21. Signature of Funeral Service Licensee	D M00831	22. Name and Addre	ess of Facility_				
Dep in your pour	The have am Muller	Fawhence.					vy Chase, Inc	
	23a. Part1. Enter the disease, or complications to	hat caused the death. Do		sin Avenue, I		ryland 200	Approximate	
	shock, or heart failure. List only one cause	on each line.	,	51	,	arrest, Appro- Interva		
Physician /Medical	immediate Ceuse (Finel							
Examiner	disaasa or condition resulting in death) a. B:	ronchiogenic	Carcinoma				2 years	
		Due to (or as a	consequence of):					
axecuted n and ial-transit	b							
cata be axecuted physician and s tha bunial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due to (or as a	consequenca of):					
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ificata be axecuted globysician and as the bural-transit	resulting In death) Last	Due to (or as e	consequence of):					
	d							
that the death certified by the attending datached for use a Physician M.								
by the stached	Part II. Other eignificant conditions contributing	to death but not resulting I	n tha undarlying ceusa gi	van in Part I.	23b. Did tobac		to the cause of death	
d by		t Disease			1 Yee	2□ No 3□ P	robably 4 💆 Unknow	
2 68 5		c Diocase				045	Alora automou fin din na	
Physician: The law requires this certificate has been sign ral director, page 2 should be					24a. Wes an au performed	?	Were eutopsy findings available prior to completion of cause	
has b							of death?	
The law ata has b					1 ☐ Yes	2 X No	1 ☐ Yes 2 ☐ No	
Certificata				26. Plece of Deeth	(Check only one)			
Physician: this certific ral diractor,	examiner? 1 X Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/O	utpatient 3 DOA Ot	her: 4 Nursing Hor	ne 5 X Residence	8 Other (Spe	city)	
			Time of 28c. Inju	ry at	28d. Describe how in	njury occurred		
tal or Attending Pars after death. el Director: After tied in by the funerical cartification:	1 ZNatural 5 Pending (2 Accident investigation	month, bey reary		Yes 2 No				
of or Attending a ster death. Director: Af in by the fu	3 Suicide 6 Could not be determined 28e. F	Placa of injury - At home, fo building, etc. (Specify)	arm, street, factory, offica	- 2	28f. Location (Street City or Town, St	end Number or Re	ural Route Number,	
d in	Tomole	Juliding, etc. (Specify)			Ony or rown, or	210/		
Hospital or Attending 24 hours after death. Puneral Director: After the fine that filled in by the fune float Certification	29a. Certifier 1X Certifying Phyaician: To							
he Hospit in 24 hour he Funer pletaly fill	(Check only 2 Medical Examiner: On the one)	he basis of examination ar manner stated.	d/or Investigation, in my	opinion, death occurre	ed at the time, date a	and place, end due	to the cause(s)	
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	29b. Signature and title of certifier		29c. Licen	sa number	29d.	Date signed (Mont	h, Dey, Year)	
	111	0 m - lo	5 50	602	(0	129/00		
13+1	dereny V	OF FER		200		(-1(7)		
	30. Name and address of person to completed							
	Jeremy V. Cooke, M.D. 31. Date filed (Month, Day, Year)		ecticut Aver	nue, #606,	Kensingt	on, MD	20895-3910	
State	JUL 01 1999	32. Registrer's Signature	G. Spork	,				
Registrar	JOF AT 1222	1	. BOOK	2/				

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Ivia	iyianu		ficate of	Death	,	Reg. No.	99	21996
	Physic	ian	1. Decedent's Name (First, Middle, Last)						2. Date of De Month	ath Day	Year	3. Time of Death
7	/Medi	cal	INST FRANCES 4a. Facility Neme (If not institution, give	1	-			4h Cit. Town and	JULY		1999	300 AM
	Exami	ner	BLOOKE GROVEREHABI		20.11	PEINE		4b. City, Town, or L			y of Death	
	Funeral		5. Social Security Number 6. Sec				Under 1 Yeer				9 Right	
	Director		199-09-2429	M 21€F	80	Yrs. M	onths Days	Hours Min.	8. Date of Bird (Month, De July 2	y, Year)	Penr	ilece (State or Foreign itry) 1Sylvania
	D .		Usual Residence of Decedent 10a. State 10b. County		10a Cib. 1	Town or Locati						
	sho	70					on				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28a-l	Directo	Maryland Montgomer	У	Whea		10f. Zip Code			10g. Citizen of	M/hat Caus	
	3a or	ā	11304 Galt Avenue				20902					try
	death	Funeral		12. Wes Decedent Ev	ver in U,S.	13. Was		tispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No	USA - 14. Ra	ce - Americ	
0200-61212	in 72 hours efter death with the Maryland "netural", or frems 23a or 28a-f show ledges Examinet main be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			yes 2⊠ No		Rican, etc.)	Specil	y: White,	
-c	72 ho	eted	15. Decedent's Educ (Specify only highest grade	ation		16a. Decedent	's Usual Occup	pation	kina	16b. Kind of E	Business/Inc	dustry
7	5 6 6	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of world)	· · · · · · ·			
-	e filed wi al Hygien other th vant, me	CO	17. Father's Neme (First, Middle, Last)	2		Shoes	sales	clerk 18. Mother's Nam	o /First Middle	Clothi		
<u> </u>	a la b	o Be	John Heffron							warden Sumer	110)	
	s 1 and 2 should be f Health end Menta fem 27 is marked other traumatic ev	To	19e. Informant's Name/Relationship (Type	oe, Print)		19b. Meiling A	ddress (Street	Helen Mo		er, City or Town	. Stete. Zip	Code)
Ma	Tand 2 Health e		Michael Boyle /	Son				ham Court				
ນ .	of He man		20a. Method of Disposition		20b. Plac	e of Disposition	on (Neme of any or other ple	00)	Date	20c. Location		
diffino	ment o		1 □XBunal 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State		of Hea		ال	999	Silver	Sprin	g. MD
0	permit. Peges 1 and 2 Depertment of Health Important: If Item 27 II any Injury or other tra once.		21. Signature of Juneral Servica License	0	1	22. Ne	ame and Addre	ess of Facility				0,
	40 E a a		of heven I	utous	m	500	Univer	Collins sity Blvd	. W. Si	lver Sp	Inc. ring,	MD 20901
			23e. Part 1. Enter the disease, or complice shock or heart failure. List only on	ations thet caused the cause on each line	he death.	Do not enter th	ne mode of dyi	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
9	'hysician /Medical		Immediate Cause (Finel	0		100					i	Onset and Death
	Examiner		disease or condition resulting In death) a	PNEUM				E)			I	DAYS
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	me ray requires tree the deets certificate be exactled attending physician end page 2 should be detached for use es the burial-transit	ted	CEREBRAL INF						24a. Was	an autopsy med?	ava	ere eutopsy findings allable prior to
	as be	Completed	Carba, e (R)	100.3	(17)	CAL	10-10				of o	npletion of cause death?
e E	certificate has b	Con							101	es 28 No	1□	Yes 2 No
Telen I	Sertifi	Be	25. Was case referred to medical examiner?	ospital:			011	26. Plece of Deal	h (Check only o	ne)		
2 4	this ald di	: To	1 ☐ Yes 2 No	1 ☐ Inpatient 28a. Dete of Injury		Outpatient 3	DOA Oth	4 par Nursing Ho	ome 5 Resid)
	order: After this certificate he by the funeral director, page	cation	1 Natural 5 ☐ Pending investigation	(Month, Dey Y	rear)	Injury	28c. Injur Wor M 1 □	k? Yes 2 □ No	200. 0 6301106 11	ow injury occur	160	
N N	s after d	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Placa of Injury building, etc. (/ - At home (Specify)	, farm, street,	factory, office		28f. Location (5 City or Tow	itreet and Numl n, Stete)	ber or Rural	Route Number,
To the Hospital or Attending Bhusicles:	within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical	29a. Certifler (Check only one) 157 Certifying Physical Control Contr	clan: To the best of r er: On the basis of er and manner stete	xamination	dge, death occ end/or Investi	curred at the tir gation, in my o	ne, dete and place, pinion, death occur	and due to the d red at the time, d	ause(s) and maidate and piece,	anner as sta and due to	ated. the cause(s)
Toth	To the comp	Me	29b. Signature end title of certifier				29c. Licens	e number		29d. Date signe	d (Month, L	Jey, Year)
	0		· com s	STAPE PH	YSICI	AN	P42	046		JULY	1,10	199
			30. Name and address of person who con	pleted cause of dea	th (Item 23	le) (Type, Print)				4	20860
			GRACE BROOKE HUP				E SCHOO	LKOAD S	ANDY S	PRING	MAR	MUAND
	Sta	te	31. Date filed (Month, Dey, Year)	32. Registrar's	s Signature	4	1					

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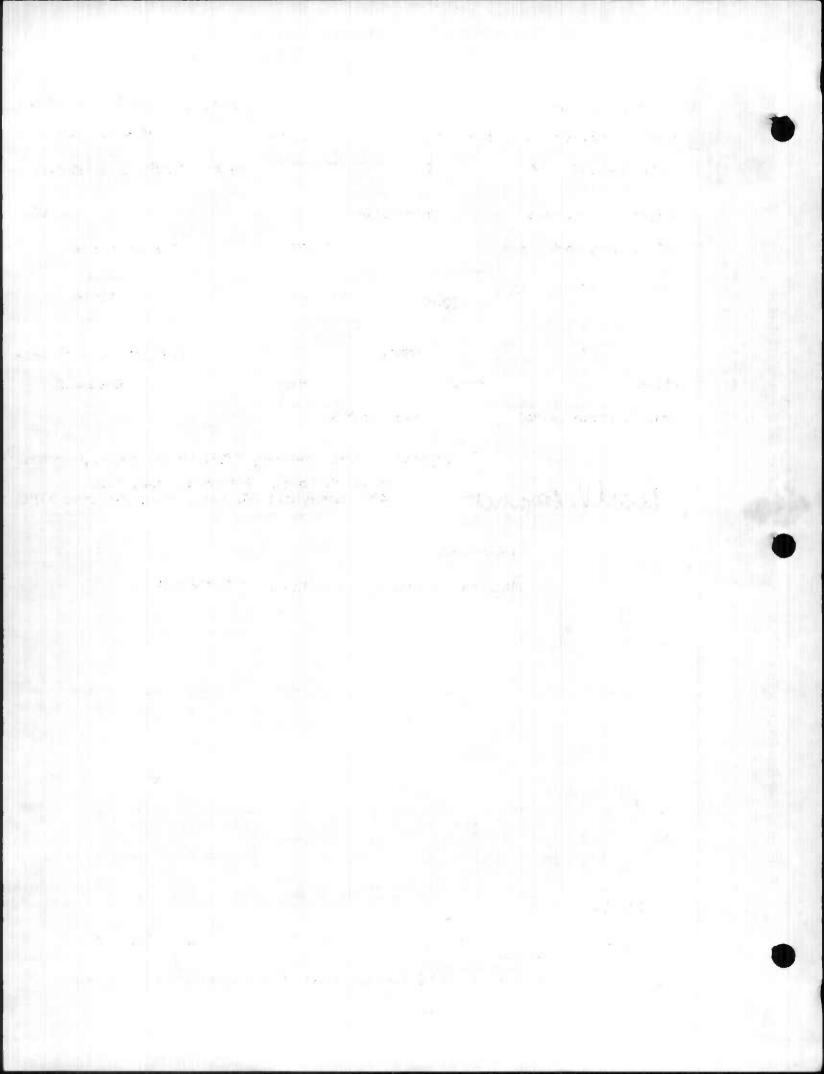
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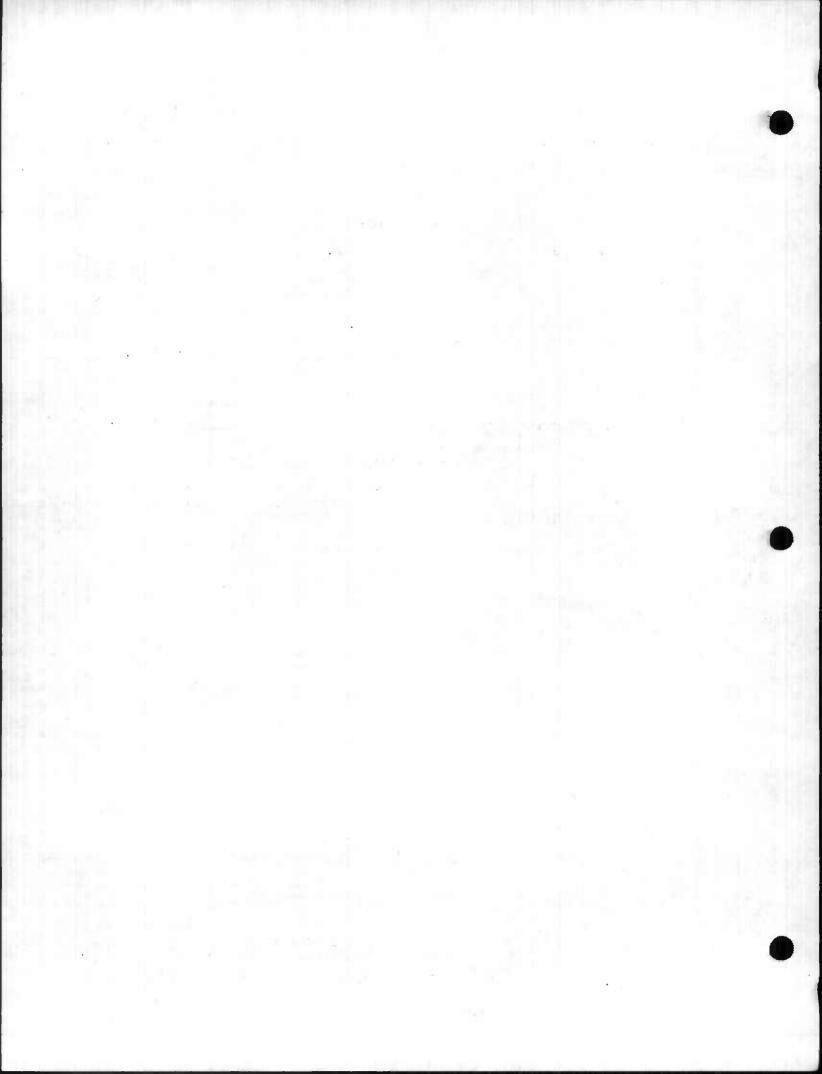
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Wesley A. Bryan 4s. City, Town, or Location of Death Montgomery 5. Social Security Number 214-28-8866 WM 22 F 5. Social Security Number 214-28-8866 WM 22 F 5. Social Security Number 214-28-8866 WM 22 F 69 Vrs. 10c. City, Town or Location Monts Days Monts						artment of F rtificate of				eg. No.	-	1
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Specify Spec	I Direc		Drive				0905					
18b. Informart's Name/Relationship (Type, Print) 18b. Malling Address (Street and Number or Rival Route Number, City or Town, State, Zip Code) 20b. Was as #10 20b. Place of Disposition (Name as	by Funera	1 Never Married XX Married	rces? 2 No		If Yes, specify Cuba	gin? (Spec , Puerto R	ify Yes or No- icen, etc.)	Blac	k, White, e	tc.		
19b. Informant's Name-Pieletonaho (Type, Pinn) Wond C. Bryan (wife) 20s. Method of Disposition 1006/risis 2 Cremetion S Permovel from State 4 Donation S Demoved From State 4 Donation S Demoved From State 4 Donation S Permovel from State 5 Donation S Permovel from State 5 Donation S Permovel from State 5 Donation S Permovel from State 5 Donation S Permovel from State 5 Donation S Permovel from State 5 Donation S Permovel from State 5 Donation S Permovel from State 5 Donation S Permovel from State 6 Donation S Permovel from State 6 Donation S Permovel from State 6 Donation S Permovel from State 6 Donation S Permovel from State 6 Donation S Permovel from State 6 Donation S Permovel from State 6 Donation S Permovel from State 6 Donation S Permovel from State 6 Donation S Permovel from State 7 Donation S Permovel from State 8 Donation S Permovel from State 8 Donation S Permovel from State 8 Donation S Permovel from State 9 Donation S Permovel from State 9 Donation S Permovel from State 9 Donation S Permovel from State 9 Donation S Permovel from State 9 Donation S Permovel from State 9 Donation S Permovel from State 9 Donation S Permovel from State 9 Donation S Permovel from State 9 Donation S Permovel from State 9 Donation S Permovel from State 9 Donation S Permovel from State 9 Donation S Permovel from State 9 Donation S Permovel from State 9 Donation S Permovel from State S Permovel from	npleted	(Specify only highest g	rede completed)		(Give life.	kind of work done DO NOT use retired	dunna most	of working	9			
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Wona C. Bryan (wife) 20a. Method of Disposition (Name of Date 20c. Location - City or Town, State 1	To Be	Allan					Mary	7			Cor	
Maryland Coremeton Commence							end Numbe	r or Rural	Route Number	, City or Town,	Stete, Zip (Code)
Application Some (Specify) Maryland Veterans Cemetery 7/6/1999 Cheltenham, Maryland Check only one Check only o		20a. Method of Disposition		20b. Plac	ce of Dispo	osition (Neme of	001		Date	20c. Location -	City or Tow	m, State
21. Signature of Funeral Service Licensee Date 1				State				erv	7/6/199	9 Chelt	enhar	m.Marvla
239. Part I. First the disease, or-computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart allure. Ust only one-cause on each line. PNEN MONTH Bequentially list conditions, flavy, leading to immediate ceves. Enter Underlying has initiated events resulting in death). Due to (or as a consequence of): Aguillow Dimmwood Pic (Back) Bequentially list conditions, flavy, leading to immediate ceves. Enter Underlying has initiated events resulting in death). Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): Aguillow Dimmwood Pic (Back) Due to (or as a consequence of): Aguillow Dimmwood Pic (Back) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death of the cause of death of ceuse performed? 24b. West cause referred to medical events performed? 25b. Was case referred to medical events performed? 27b. Manner of Deeth Dispinal in Impatient 2 Perfoughetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27b. Manner of Deeth Dispinal in Impatient 2 Perfoughetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27b. Manner of Deeth Dispinal investigation 3 Doa Other, 4 Nursing Home 5 Residence 6 Other (Specify) 27b. Manner of Deeth Dispinal investigation and only the death of the cause of the contribute of the cause of the contribute of the cause of the contribute of the cause of the contribute of the cause of the contribute of the cause of the contribute of the cause of the contribute of the cause of the contribute of the cause of the contribute of the cause of the contribute of the cause of the contribute of the cause of the contribute of the cause of the contribute of the cause of the contribute of the cause of the cause of the contribute of the cause of the contribute of the cause of the contribute of the cause of the contribute of t		21. Signature of Funeral Service Lic	ensee	4	Î	Name and Addre	Borgv	vardt	Funera	1 Home	P.A	•
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Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check pm) one) Natural 2 Accident 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check pm one) Natural 2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28e. Location (Street and Number or Rurel Route Number, 28e. Location (Street and Number or Rurel Route Number, 28e. Location (Street and Number or Rurel Route Number, 28e. Location (Street and Number or Rurel Route Number, 28e. Location (Street and Number or Rurel Route Number, 28e. Location (Street and Number or Rurel Route Number, 28e. Location (Street and Number or Rurel Route			101	7		nt 3LI DOA	4 LI NU	-)
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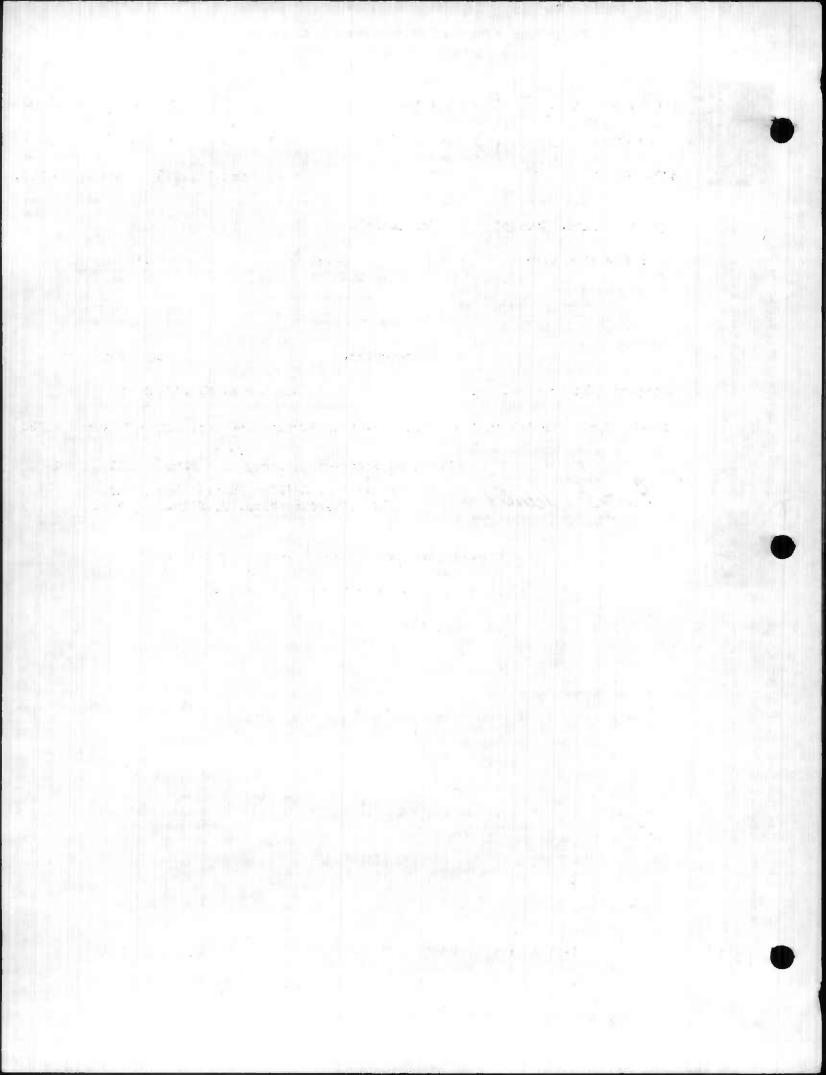
State of Maryland / Department of Health and Mental Hygiene

		Certificate of D	Peath	Reg. No.	21330								
Dhualalau	1. Decedent's Nama (First, Middla, Last)		2. Data of i	Death Day Year	3. Tima of Death								
Physician /Medical	Mary Cecelia Buscher		June	24 1999	7:40 PM								
Examiner	4a Facility Nama (If not institution, giva street and number)	4b	. City, Town, or Location of Dec										
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Funeral	5. Social Sacurity Number 6. Sax 7. Aga (In yrs.	Months Days	Hours Min. 8. Dete of E	lirth 9. Birth	hplaca (State or Foreign untry)								
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B	Usual Residence of Decedant 10e. Stata 10b. County 10c. Cit	ty, Town or Location			10d. Inside City Limits								
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Tect notifi	Maryland Montgomery 10e. Street and Number	Silver Spring 10f. Zip Code		10g. Citizen of What Co	untry?								
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ther death with the Maryla r thems 23s or 28s-f sho siner must be notified at funeral Director	11. Marital Status 12. Was Decedant Evar in U		panic Origin? (Specify Yas or I , Mexican, Puerto Rican, atc.)	USA to- 14. Race - Amai	rican Indian,								
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be filed within 72 ho lai Hygiene. d other than 'naturn event, the Medical.	15. Decedent's Education	16a. Decedent's Usual Occupat (Giva kind of work dona du	ion	16b. Kind of Business/I	ndustry								
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d 2 should be fie h and Mertal Hy 7 is marked other traumetic event To Be (17. Fathar's Name (First, Middle, Last)		18. Mother's Name (First, Midd	le, Maiden Surname)									
should b nd Monta manked umeric e	George Buscher		Ella Fahey										
2 sho	19e. Informant's Name/Ralationship (Type, Print)	19b. Meiling Address (Street ar	nd Number or Rural Routs Num	ber, City or Town, State, Z	(ip Code) 22041								
25 10 24 1	Bessie C. Buscher (sister-in-la	w) 5597 Seminar	y Road #1406 S		ch, VA								
emit. Pages 1 ar Department of Hea Important; if Item 2 Iny Injury or other 2008.	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata	Plece of Disposition (Nama of cematary, crematory or other place)	Data	20c. Location - City or	Town, Stata								
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and and and and and and and and and and	21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Francis J. Collins Fuenral Home, Inc.												
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	23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.	th. Do not entar tha moda of dying	, such as cardiac or respiratory	arrast,	Approximata tniarval Between								
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The law require set a has been single page 2 should Completed			pa		evailable prior to completion of cause								
The law page 2				7.5	of death?								
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yaician: Tha I is cartificata he director, paga	25. Was case refarred to madical axaminar? Hospital:	Other	26. Place of Death (Check only										
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la for Attending P rs affar death. al Director: Affar t led in by the funers Certification:	4 Homicida datamined building, etc. (Specif	(y)	City or 7	own, Stata)									
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After complately filled in by the fune Medical Certification	29e. Certifiar (Check only one) 1 Certifying Physician: To the best of my kno												
ithin 2 the omple	one) end mannar stated. 29b. Signatura and titla of cartiflar	29c. License	number	29d. Data signed (Month	h. Dav. Year)								
F ≱ F 8	Nevy C. Sir, Jr.			6-25-9									
9	7												
12.1	30. Nama and addrass of parson who complated causa of death (Item George C. Hayar, Jr. m. 0		Blud Lanka	m, md 20	706								
State Registrar	31. Data filed (Month, Day, Year) 32. Registrer's Signa	G. Sparker											



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate of	Death	Reg. No.		
Physician	1. Decedent's Name (First, Middle, Last	The latest to th	br		ete of Death	Yeer	3. Time of Deeth
/Medical	Gregory	J Bussin	12,00,	•	une 29	1999	Ad. E.
Examiner	4a Facility Neme (If not Institution, give		14:00	Chever L		ounty of Death	seorge's
•	5. Social Security Number 6. Se	x 7. Age (In yrs. las		1 1011 1 2011 1 2	ate of Birth		
Funeral Director		XM 2□ F 72	Yrs. Months Days	Hours Min. (A	t. 24, 1926		place (State or Foreign htry) ington, D.C.
yland w	10a. State 10b. County	10c. City,	Town or Location			1	10d. inside City Limite
death with the Mandand ms 23s or 28s-f show Livest be notified at neral Director	Maryland Prince G	eorge's Ne	ew Carrollton				1 Yes 2 No
or 28a-1 so the market of the mountainer	10e. Street and Number		10f. Zip Code		10g. Citize	n of What Cour	ntry?
ath w	8106 Powhatan St		207			USA	
r items 23s	11. Marital Stetus	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify Cut	Hispenic Origin? (Specify) pan, Mexican, Puerto Ricar	Yes or No- n, etc.)	. Race - Americ Black, White,	
by	1 ☐ Never Merried 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorcad	1 ⊈Yes 2 □ No If Yes, Give Year or Detes: WWII	1□ Yes 24ूर No	Specify:	S	pecify: Whi	te
n 72 hours natural, notes Ex	15. Decedent's Edu (Specify only highest grad		16e. Decedent's Usual Occu (Give kind of work done	during most of working	16b. Kind	of Business/inc	dustry
	Elementary/Secondery (0-12)	College (1-4or 5+)	life. DO NOT use retire	9d)	7-1	1 0	
filed within Hygiene. Ather than ent, man, me Comp	17. Fether's Neme (First, Middle, Last)	4	Accountant	18. Mother's Name (Firs		ral Gov	ernment
should be filed within and Mental Hygiene. marked other than imetic event, the M	Gregory John Bus	sink. Sr		Lillian H			
and Men and Men amarke sumatic	19e. Informant's Name/Reletionship (7)		19b. Melling Address (Stree				Code)
permit. Pages 1 and 2 should be filed Depertment of Heelth and Mental Hyg Important: If Itsm 27 is marked other any injury or other treumetic event, ance. To Be C	Dorothy Marie Bus 20a. Method of Disposition 1園Burial 2 □Cremation 3 □ 1 □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	20b. Pla cent	3106 Powhatan ce of Disposition (Name of netery, cremetory or other pla yland Veteran: 22. Name and Addr Francis J	7/2 S Cemetery	20c. Loca /99 Crown	nsville	land 20784 own, State ,Maryland
	gru s. so	ines	500 Unive	rsity Blvd.	W. Silver		, MD 20901
	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death. ne ceuse on each line.	Do not enter the mode of dy	ing, such as cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death
Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	-	as e consequence of):	1. 1	pathy		
at the death certificate be executed by the attending physicien and letached for use as the burial-transit Physician/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Diabo	s e consequence of):	y dixa	re .		
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been shoul	<u></u>		•		24e. Was en eutops: performed?	av co	fere autopsy findings vallable prior to ompletion of cause deeth?
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fter thuneral	27. Menner of Death 1 ☑Netural 5 ☑ Pending	28e. Dete of Injury (Month, Day Year)	8b. Time of 28c. Injury We	ork?	Describe how Injury	occurred	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Placa of injury - At hom building, etc. (Specify)	M 10		ocation (Street and City or Town, State)	Number or Run	al Route Number,
polital ours ours filled	29a. Certifier 1 Certifying Phy	aician: To the best of my knowle	edge, death occurred at the t	ime date and place, and d	lue to the cause(s) a	nd manner es s	stated
he Hospi in 24 hou he Funer pletely fill edical		ner: On the basis of examinetio end manner stated.					
12+1	29b. Signature and title of certifier	th'MI		054068		signed (Month, 29, 1999	
	30. Name and eddress of person who co	ompleted cause of deeth (Item 2	13a) (Type, Print) Prince 6	eorge Ho:			
State	31. Date filed (Month, Day, Year)	32. Registrar's Signatu		, ,	1		-1
Registrar	JUL 02 1999	3 Seneva	D. Spark				



State of Maryland / Department of Health and Mental Hygiene

2.6.000 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Tima of Death **Physician** 2310 1000 MARY ELIZABETH **BOWMAN** JUNE /Medical 4a Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES GEORGES HOSPITAL CHEVERLY PRINCES CENTER Birthplace (Stata or Foreign Country) If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, **Funeral** Months Days Hours 1 □ M 2 1 F 218-01-2753 78 Sept. 10,1920 South Carolina Director Usual Residence of Decedent the Meryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or flams 23a or 28a-f show 1 Yes 2 No Director St. Mary's Maryland Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. ther then "natural", or flems 23a or 2 43184 Riverside Drive 20636 U.S.A. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11 Maritel Status 12. Wes Decedent Ever in U,S. Armed Forces? Bleck, White, etc. 1 Yes 2 No If Yas, Giva Year or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumame) Be Pages 1 and 2 should be north of Health and Mental James Henry Smith Rosalie Timms 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda) epartment of Health , important: If Health , any Injury or other , and ange. Marion L. Fogle, Jr./Son P.O. Box 495, Hollywood, Maryland 20636 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Maryland Veterans' Cem. 6-30-1999 Cheltenham, Maryland A Other (Specify) 22. Name and Address of Fecility 21. Signat e of Funeral Service Licens The Huntt Funeral Home MARK G. BROHAWN M00053 P.O. Box 156, Waldorf, Maryland Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, or haart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical INJURIES WITH COMPLICATIONS MULTIPLE Examiner Dua to (or as a consequence of) Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Entar Underlying Cause (Disease or injury that initiated events resulting in daath) Last Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) for use as signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ The law requires 24b. Were autopsy findings eveilable prior to completion of cause of death? bluods 24a. Was an autopsy performed? Completed page 2 s 2 X No 1 ☐ Yas 2 ☐ No certificate 1 Yes Division of Vital Physician: director 25. Was case referred to medicel examiner? 26. Placa of Death (Check only one) Be Hospital: 2 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 4 funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred DRIVER OF AUTO 28b. Tima of Injury Certification: VS TRUCK or Attending 1 Natural 5 Pending 1415 death. 2 Accidant 3 Suicide investigation 06-15-99 1 Yes 2 No Director: / COLLISION 6 Could not be detarmined Location (Streat and Number or Rural Route Number, City or Town, Stata) Ho LYWOOV, MARYLAND 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 4 - Homleida 24 hours aft Funeral Di STREET ROUTE 235 & JONES WHARF RD Hospital edicai 29a, Cartifia Certifying Phyeician: To the best of m 2 Medical Examinar: On the basis of examinar manner of the Certifying Phyeician: To the best of my knowledge, death occurred at the time, data and place, and due to the ceuse(s) and manner as stated. (Check only pation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2 29d. Dete signed (Month, Day, Year) JUNE 28, 1999 30. Name and address of person who completed cause of deals 3a) (Type, Print) PRIVE, CHEVERLY, MARYLAND 20785 MARIO F. GOLVE 3001 MO 31. Date filed (Month, Dey, Year) 32. Registrar's Signatura JUL 02 Registrar

